EXECUTIVE SUMMARY

1 Apr 2012

(FOUO) AR 15-6 inquiry into (b)(6) Command and Possible Improper Influence on Forensic Psychiatry/Psychology section (FPS) at MAMC

(b)(6) was appointed investigating officer (IO) by MG Volpe. His report is complete and ready for action by the CG, WRMC.

The IO was charged to assess the "command climate," especially from the standpoint of Soldier care. The IO was also charged to determine whether (b)(6) exercised any improper influence over the FPS diagnoses. The IO interviewed approximately twenty five personnel, to include JBLM commanders, hospital staff, and the ombudsmen.

The IO found that:

a. The prevailing command climate at MAMC created by (b)(6) particularly as it relates to Soldier care, is extremely positive and appropriate; he is almost universally considered one of the, if not the, finest hospital commanders ever assigned to MAMC.

b. (b)(6) did not inappropriately direct or influence the activities or development of diagnosis of the MAMC forensic psychology/psychiatry section (FPS) in the Army Physical Disability Evaluation Process. His only influence was an effort to make accurate diagnoses based on the on the medical evidence using established medical standards within the field of psychiatry. (b)(6) did not direct, mandate, or influence FPS providers to change diagnosis or conclusions of Post Traumatic Stress Disorder (PTSD) from PTSD-yes to PTSD-no, or to some similar conclusion during the APEDS process. He did not heighten the level of scrutiny the FPS providers employed in assessing behavioral health diagnoses.

c. (b)(6) had no involvement whatsoever in any FPS cases until the fall of 2011 and then he only reviewed a few cases which had come to his attention thorough Congressional inquiries. In September 2011 he met with (b)(6) in an apparent effort to address her concerns about some of the diagnoses being rendered by some of the providers. (b)(6) reviewed some of the findings of the FPS, which he concurred with, and supported in all cases. The IO found that, given that (b)(6) is not a psychiatric doctor, and that FPS diagnostic practices had been considered to be the most accurate, it was reasonable for him to respond in the manner that he did; to review the matter and to defer to the FPS providers. This was especially appropriate given that (b)(6) is not a provider, does not have an FPS background, and that she not objective or credible in her dealings with providers.

The IO felt that the concerns with FPS stem from lack of understanding about FPS and its duty to render the most accurate behavioral health diagnoses possible. The IO recommends:

a. (b)(5)

b. (b)(5)

(b)(5)

(b)(6)

LIST OF EXHIBITS

E1

REPORT OF PROCEEDINGS BY INVESTIGATING OFFICER/BOARD OF OFFICERS

For use of this form, see AR 15-6; the proponent agency is OTJAG.

IF MORE SPACE IS REQUIRED IN FILLING OUT ANY PORTION OF THIS FORM, ATTACH ADDITIONAL SHEETS

SECTION I - APPOINTMENT

Appointed by MG Philip Volpe
(Appointing authority)

on 24 Feb 2012 *(Attach Inclosure 1: Letter of appointment or summary of oral appointment data.) (See para 3-15, AR 15-6.)*
(Date)

SECTION II - SESSIONS

The *(investigation) (board)* commenced at WRMC HQ, JBLM *(Place)* at 0900 *(Time)*

on 27 Feb 2012 *(If a formal board met for more than one session, check here* ☐ *. Indicate in an inclosure the time each session began and ended, the place, persons present and absent, and explanation of absences, if any.)* The following persons *(members, respondents, counsel)* were present: *(After each name, indicate capacity, e.g., President, Recorder, Member, Legal Advisor.)*
(Date)

The following persons *(members, respondents, counsel)* were absent: *(Include brief explanation of each absence.) (See paras 5-2 and 5-6a, AR 15-6.)*

The *(investigating officer) (board)* finished gathering/hearing evidence at _____ *(Time)* on 9 Mar 2012 *(Date)*

and completed findings and recommendations at _____ *(Time)* on 21 Mar 2012 *(Date)*

SECTION III - CHECKLIST FOR PROCEEDINGS

	A. COMPLETE IN ALL CASES	YES	NO 1/	NA 2/
1	Inclosures *(para 3-15, AR 15-6)* Are the following inclosed and numbered consecutively with Roman numerals: *(Attached in order listed)*			
	a. The letter of appointment or a summary of oral appointment data?	☑	☐	
	b. Copy of notice to respondent, if any? *(See item 9, below)*	☐	☐	☑
	c. Other correspondence with respondent or counsel, if any?	☐	☐	☑
	d. All other written communications to or from the appointing authority?	☐	☐	☑
	e. Privacy Act Statements *(Certificate, if statement provided orally)*?	☑	☐	☐
	f. Explanation by the investigating officer or board of any unusual delays, difficulties, irregularities, or other problems encountered *(e.g., absence of material witnesses)*?	☐	☐	☑
	g. Information as to sessions of a formal board not included on page 1 of this report?	☐	☐	☑
	h. Any other significant papers *(other than evidence)* relating to administrative aspects of the investigation or board?	☑	☐	☐

FOOTNOTES: *1/ Explain all negative answers on an attached sheet.*
2/ Use of the N/A column constitutes a positive representation that the circumstances described in the question did not occur in this investigation or board.

		YES	NO 1/	NA 2/
2	Exhibits *(para 3-16, AR 15-6)*			
	a. Are all items offered *(whether or not received)* or considered as evidence individually numbered or lettered as exhibits and attached to this report?	☑	☐	☐
	b. Is an index of all exhibits offered to or considered by investigating officer or board attached before the first exhibit?	☑	☐	☐
	c. Has the testimony/statement of each witness been recorded verbatim or been reduced to written form and attached as an exhibit?	☑	☐	☐
	d. Are copies, descriptions, or depictions *(if substituted for real or documentary evidence)* properly authenticated and is the location of the original evidence indicated?	☑	☐	☐
	e. Are descriptions or diagrams included of locations visited by the investigating officer or board *(para 3-6b, AR 15-6)?*	☑	☐	☐
	f. Is each written stipulation attached as an exhibit and is each oral stipulation either reduced to writing and made an exhibit or recorded in a verbatim record?	☑	☐	☐
	g. If official notice of any matter was taken over the objection of a respondent or counsel, is a statement of the matter of which official notice was taken attached as an exhibit *(para 3-16d, AR 15-6)?*	☐	☐	☑
3	Was a quorum present when the board voted on findings and recommendations *(paras 4-1 and 5-2b, AR 15-6)?*	☐	☐	☑
B. COMPLETE ONLY FOR FORMAL BOARD PROCEEDINGS *(Chapter 5, AR 15-6)*				
4	At the initial session, did the recorder read, or determine that all participants had read, the letter of appointment *(para 5-3b, AR 15-6)?*	☐	☐	
5	Was a quorum present at every session of the board *(para 5-2b, AR 15-6)?*	☐	☐	
6	Was each absence of any member properly excused *(para 5-2a, AR 15-6)?*	☐	☐	☐
7	Were members, witnesses, reporter, and interpreter sworn, if required *(para 3-1, AR 15-6)?*	☐	☐	☐
8	If any members who voted on findings or recommendations were not present when the board received some evidence, does the inclosure describe how they familiarized themselves with that evidence *(para 5-2d, AR 15-6)?*	☐	☐	☐
C. COMPLETE ONLY IF RESPONDENT WAS DESIGNATED *(Section II, Chapter 5, AR 15-6)*				
9	Notice to respondents *(para 5-5, AR 15-6):*			
	a. Is the method and date of delivery to the respondent indicated on each letter of notification?	☐	☐	
	b. Was the date of delivery at least five working days prior to the first session of the board?	☐	☐	
	c. Does each letter of notification indicate —	☐	☐	
	(1) the date, hour, and place of the first session of the board concerning that respondent?	☐	☐	
	(2) the matter to be investigated, including specific allegations against the respondent, if any?	☐	☐	
	(3) the respondent's rights with regard to counsel?	☐	☐	
	(4) the name and address of each witness expected to be called by the recorder?	☐	☐	
	(5) the respondent's rights to be present, present evidence, and call witnesses?	☐	☐	
	d. Was the respondent provided a copy of all unclassified documents in the case file?	☐	☐	
	e. If there were relevant classified materials, were the respondent and his counsel given access and an opportunity to examine them?	☐	☐	☐
10	If any respondent was designated after the proceedings began *(or otherwise was absent during part of the proceedings):*			
	a. Was he properly notified *(para 5-5, AR 15-6)?*	☐	☐	☐
	b. Was record of proceedings and evidence received in his absence made available for examination by him and his counsel *(para 5-4c, AR 15-6)?*	☐	☐	☐
11	Counsel *(para 5-6, AR 15-6):*			
	a. Was each respondent represented by counsel?	☐	☐	
	Name and business address of counsel:			
	(If counsel is a lawyer, check here ☐ *)*			
	b. Was respondent's counsel present at all open sessions of the board relating to that respondent?	☐	☐	☐
	c. If military counsel was requested but not made available, is a copy *(or, if oral, a summary)* of the request and the action taken on it included in the report *(para 5-6b, AR 15-6)?*	☐	☐	☐
12	If the respondent challenged the legal advisor or any voting member for lack of impartiality *(para 5-7, AR 15-6):*			
	a. Was the challenge properly denied and by the appropriate officer?	☐	☐	☐
	b. Did each member successfully challenged cease to participate in the proceedings?	☐	☐	☐
13	Was the respondent given an opportunity to *(para 5-8a, AR 15-6):*			
	a. Be present with his counsel at all open sessions of the board which deal with any matter which concerns that respondent?	☐	☐	
	b. Examine and object to the introduction of real and documentary evidence, including written statements?	☐	☐	☐
	c. Object to the testimony of witnesses and cross-examine witnesses other than his own?	☐	☐	☐
	d. Call witnesses and otherwise introduce evidence?	☐	☐	
	e. Testify as a witness?	☐	☐	
	f. Make or have his counsel make a final statement or argument *(para 5-9, AR 15-6)?*	☐	☐	
14	If requested, did the recorder assist the respondent in obtaining evidence in possession of the Government and in arranging for the presence of witnesses *(para 5-8b, AR 15-6)?*	☐	☐	☐
15	Are all of the respondent's requests and objections which were denied indicated in the report of proceedings or in an inclosure or exhibit to it *(para 5-11, AR 15-6)?*	☐	☐	☐

FOOTNOTES: 1/ *Explain all negative answers on an attached sheet.*
2/ *Use of the N/A column constitutes a positive representation that the circumstances described in the question did not occur in this investigation or board.*

		YES	NO 1/	NA 2/
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	b. Is an index of all exhibits offered to or considered by investigating officer or board attached before the first exhibit?	☑	☐	☐
	c. Has the testimony/statement of each witness been recorded verbatim or been reduced to written form and attached as an exhibit?	☑	☐	☐
	d. Are copies, descriptions, or depictions *(if substituted for real or documentary evidence)* properly authenticated and is the location of the original evidence indicated?	☑	☐	☐
	e. Are descriptions or diagrams included of locations visited by the investigating officer or board *(para 3-6b, AR 15-6)?*	☑	☐	☐
	f. Is each written stipulation attached as an exhibit and is each oral stipulation either reduced to writing and made an exhibit or recorded in a verbatim record?	☑	☐	☐
	g. If official notice of any matter was taken over the objection of a respondent or counsel, is a statement of the matter of which official notice was taken attached as an exhibit *(para 3-16d, AR 15-6)?*	☐	☐	☑
3	Was a quorum present when the board voted on findings and recommendations *(paras 4-1 and 5-2b, AR 15-6)?*	☐	☐	☑
B.	COMPLETE ONLY FOR FORMAL BOARD PROCEEDINGS *(Chapter 5, AR 15-6)*			
4	At the initial session, did the recorder read, or determine that all participants had read, the letter of appointment *(para 5-3b, AR 15-6)?*	☐	☐	
5	Was a quorum present at every session of the board *(para 5-2b, AR 15-6)?*	☐	☐	
6	Was each absence of any member properly excused *(para 5-2a, AR 15-6)?*	☐	☐	☐
7	Were members, witnesses, reporter, and interpreter sworn, if required *(para 3-1, AR 15-6)?*	☐	☐	☐
8	If any members who voted on findings or recommendations were not present when the board received some evidence, does the inclosure describe how they familiarized themselves with that evidence *(para 5-2d, AR 15-6)?*	☐	☐	☐
C.	COMPLETE ONLY IF RESPONDENT WAS DESIGNATED *(Section II, Chapter 5, AR 15-6)*			
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	c. Does each letter of notification indicate –	☐	☐	
	(1) the date, hour, and place of the first session of the board concerning that respondent?	☐	☐	
	(2) the matter to be investigated, including specific allegations against the respondent, if any?	☐	☐	
	(3) the respondent's rights with regard to counsel?	☐	☐	
	(4) the name and address of each witness expected to be called by the recorder?	☐	☐	
	(5) the respondent's rights to be present, present evidence, and call witnesses?	☐	☐	
	d. Was the respondent provided a copy of all unclassified documents in the case file?	☐	☐	
	e. If there were relevant classified materials, were the respondent and his counsel given access and an opportunity to examine them?	☐	☐	☐
10	If any respondent was designated after the proceedings began *(or otherwise was absent during part of the proceedings)*:			
	a. Was he properly notified *(para 5-5, AR 15-6)?*	☐	☐	☐
	b. Was record of proceedings and evidence received in his absence made available for examination by him and his counsel *(para 5-4c, AR 15-6)?*	☐	☐	☐
11	Counsel *(para 5-6, AR 15-6)*:			
	a. Was each respondent represented by counsel?	☐	☐	
	Name and business address of counsel:			
	(If counsel is a lawyer, check here ☐ *)*			
	b. Was respondent's counsel present at all open sessions of the board relating to that respondent?	☐	☐	☐
	c. If military counsel was requested but not made available, is a copy *(or, if oral, a summary)* of the request and the action taken on it included in the report *(para 5-6b, AR 15-6)?*	☐	☐	☐
12	If the respondent challenged the legal advisor or any voting member for lack of impartiality *(para 5-7, AR 15-6)*:			
	a. Was the challenge properly denied and by the appropriate officer?	☐	☐	☐
	b. Did each member successfully challenged cease to participate in the proceedings?	☐	☐	☐
13	Was the respondent given an opportunity to *(para 5-8a, AR 15-6)*:			
	a. Be present with his counsel at all open sessions of the board which deal with any matter which concerns that respondent?	☐	☐	
	b. Examine and object to the introduction of real and documentary evidence, including written statements?	☐	☐	☐
	c. Object to the testimony of witnesses and cross-examine witnesses other than his own?	☐	☐	☐
	d. Call witnesses and otherwise introduce evidence?	☐	☐	
	e. Testify as a witness?	☐	☐	
	f. Make or have his counsel make a final statement or argument *(para 5-9, AR 15-6)?*	☐	☐	
14	If requested, did the recorder assist the respondent in obtaining evidence in possession of the Government and in arranging for the presence of witnesses *(para 5-8b, AR 15-6)?*	☐	☐	☐
15	Are all of the respondent's requests and objections which were denied indicated in the report of proceedings or in an inclosure or exhibit to it *(para 5-11, AR 15-6)?*	☐	☐	☐

FOOTNOTES: *1/ Explain all negative answers on an attached sheet.*
2/ Use of the N/A column constitutes a positive representation that the circumstances described in the question did not occur in this investigation or board.

SECTION VI - AUTHENTICATION *(para 3-17, AR 15-6)*

THIS REPORT OF PROCEEDINGS IS COMPLETE AND ACCURATE. *(If any voting member or the recorder fails to sign here or in Section VII below, indicate the reason in the space where his signature should appear.)*

(b)(6)

(Recorder)	*(Investigating Officer) (President)*
(Member)	*(Member)*
(Member)	*(Member)*

SECTION VII - MINORITY REPORT *(para 3-13, AR 15-6)*

To the extent indicated in inclosure _____, the undersigned do(es) not concur in the findings and recommendations of the board. *(In the inclosure, identify by number each finding and/or recommendation in which the dissenting member(s) do(es) not concur. State the reasons for disagreement. Additional/substitute findings and/or recommendations may be included in the inclosure.)*

(Member)	*(Member)*

SECTION VIII - ACTION BY APPOINTING AUTHORITY *(para 2-3, AR 15-6)*

The findings and recommendations of the *(investigating officer) (board)* are *(approved) (disapproved) (approved with following exceptions/ substitutions). (If the appointing authority returns the proceedings to the investigating officer or board for further proceedings or corrective action, attach that correspondence (or a summary, if oral) as a numbered inclosure.)*

The findings are approved.

The recommendations are taken under advisement.

See attached action.

-5 APR 2012 Russ W Thomas, MG, USA

DEPARTMENT OF THE ARMY
HEADQUARTERS, I CORPS AND JOINT BASE LEWIS-MCCHORD
BOX 339500 MAIL STOP 1
JOINT BASE LEWIS-MCCHORD, WA 98433-9500

REPLY TO
ATTENTION OF:

AFZH-GT

CORRECTED COPY

MEMORANDUM FOR Commander, Western Region Medical Command

SUBJECT: AR 15-6 Investigation Findings

1. **Investigation Mission.** The investigative mission assigned to me by MG Volpe focused on answering two central questions:

- What was the nature, appropriate or inappropriate, of the command climate that (b)(6) created at MAMC?
- Did (b)(6) inappropriately influence the MAMC forensic psychiatry section (FPS) in their evaluation of behavior health related cases, especially ones involving PTSD, during the Army Physical Disability Evaluation System (APDES) process?

2. **Methodology.** During my investigation I sought answers to these questions through detailed interviews with (b)(6), (b)(6) subordinate commanders, his immediate staff, his subordinate staff, and Soldiers assigned to the MAMC Command; Brigade Commanders assigned to both I Corps and the JBLM Garrison that (b)(6) (b)(6) and MAMC supports; and Army civilians and contractors assigned to MEDCOM who have duty at MAMC. (See Exhibits 4-21). I reviewed MAMC performance and FPS case metrics as supplied by the MAMC and the Western Region Medical Command staff. (Exhibits 24 & 25). I reviewed multiple recorded command presentation sessions by (b)(6), and finally, I considered numerous unsolicited letters, relative to (b)(6) performance as the MAMC Commander, that I received from Soldiers, retirees, and other interested parties. (See Exhibits 22, 23, 26-30).

3. **Command Climate.** On the question of command climate, there is virtually universal praise among everyone I interviewed on the positive command climate (b)(6) (b)(6) has created at MAMC and his performance as the MAMC Commander (Exhibits 5-18). (b)(6) assumed command of MAMC at a time when previous MAMC Commanders had amassed close to a 300 million dollar budget deficit, allowed an atmosphere of complacency toward holding providers accountable for patient contact hours, seen a steady decrease in the number of inpatients and outpatients served, and other declining metrics to occur all of which indicated a poor performing organization. (b)(6) assumed Command of MAMC with a clear mission from MG Volpe to

reverse MAMC's negative trends, get MAMC operating more effectively and efficiently, and (b)(6) had a personal mission to significantly improve MAMC's delivery of healthcare to Soldiers stationed at JBLM (Exhibit 4). Upon assuming command, (b)(6) (b)(6) held several command philosophy and intent presentations to inform the command of the issues facing MAMC and to impart his vision for creating a values based, standards driven organization. He established clear standards of time accountability for providers, high expectations for those in positions of leadership and responsibility, and a roadmap for reversing the negative trends of the past (Exhibit 22). Some staff initially felt uneasy with the changes and the direction that (b)(6) laid out in his vision to the command, others welcomed his fresh ideas and his focus on accountability. In the following months (b)(6) built the MAMC staff into an effective team with common goals, through regular town hall forums and other venues here he consistently reinforced his vision and philosophy and received feedback from the command, and he kept the command informed on the progress toward his envisioned endstate (Exhibit 23). By the time of this investigation, approximately seven months into (b)(6) command, his leadership was changing the course of MAMC in a very positive manner, he was clearing operating within the guidance and intent he had been assigned by MG Volpe, and he was accomplishing the mission of turning MAMC around. Members of the MAMC command who were initially skeptical of his vision had seen improvements in MAMCs performance under (b)(6) (Exhibit 24) and had become champions of his ideas and leadership style. A reoccurring comment from the hospital staff during my interviews was, "(b)(6) is one of the best hospital commanders I have ever served with." I received similar laudatory comments on (b)(6) performance as the MAMC Commander by the I Corps and JBLM Brigade Commanders I interviewed. Of special note is the intense zeal with which (b)(6) (b)(6) pursued his personal mission to improve the delivery of healthcare to Soldiers. This was echoed in the sworn statements of (b)(6) and (b)(6) (Exhibits 17, 18 & 19) where they all credited (b)(6) with a high degree of care for the Soldier as evidenced by his creation of the Soldiers Centered Care Home and the creation of the JBLM Aviation Medical Clinic. The preponderance of the evidence leads me to find that (b)(6) record of performance as the Commander of MAMC, his command climate, and his leadership style are all positive, appropriate, and what the Army expects and demands of its senior leaders and commanders.

4. **Influencing the FPS Evaluation Process.** On the question of improper influence of MAMC forensic psychiatry services' (FPS) evaluation of behavioral health related cases, there is no evidence to support any suggestion of wrong doing on the part of

(b)(6). The evidence clearly shows that the only guidance or influence that (b)(6) (b)(6) ever gave to the FPS section was to make accurate diagnosis, based on the medical evidence, using the medical standards defined for the profession and established by applicable Army Regulation and policies. Every MAMC Behavioral Health leader and provider I interviewed emphatically denied, under repeated questioning, that (b)(6) had any influence on FPS diagnostic findings and all confirmed that (b)(6) only gave general guidance to FPS to make accurate diagnosis, based on the medical evidence (Exhibits 5, 9 & 14). Other, non Behavioral Health, MAMC leaders who were in positions to know of any guidance (b)(6) would have issued to FPS, confirmed that (b)(6) did not influence the FPS evaluation process and gave clear guidance to get diagnosis right based on the medical evidence only (Exhibits 6, 7, 8, 10, 12 & 13). During the course of my investigation I could only find two individuals, the two MEDCOM Ombudsman, who made unsubstantiated allegations of improper influence, by unknown persons, on the FPS evaluation process (Exhibits 20 & 21). Specifically, the two MEDCOM Ombudsmen were suspicious that MAMC FPS was changing some Soldiers diagnosis of PTSD-yes to PTSD-no because the large financial costs to the U.S. government incurred (in the way of benefits) when a diagnosis of PTSD-yes was given to a Soldier. During questioning, both ombudsmen stated that they did not believe (b)(6) improperly influenced the FPS section nor was he the source of any guidance to use financial consideration when diagnosing PTSD. Additionally I could find no evidence to support the suspicions of improper influence of the two MEDCOM Ombudsmen. I do find that the source of the MEDCOM Ombudsmen's suspicions of improper financial influence stems from their ignorance of the FPS evaluation process and a statement made by (b)(6) (b)(6) at a 1 September briefing he gave on the FPS evaluation process that the Ombudsmen took completely out of context and used as confirmation of their theories of improper financial influence to explain why FPS downgraded some Soldiers PTSD diagnosis from PTSD-yes to PTSD-no (Exhibits 4, 5, 7, 9 & 14). Contrary to the MEDCOM Ombudsmen's unsubstantiated suspicions, the evidence clearly establishes that FPS appropriately uses the medical evaluation standards set forth by the Diagnostic and Statistical Manual of Mental Health (DSM4TR) and Army Regulation 40-400 (Exhibits 5, 7, 8, 9 & 14), and nothing else, when evaluating Soldier's with behavioral health diagnosis during the APDES process. FPS's evaluations are conducted thoroughly and in great detail using multiple evaluation tools and reviewing all available records and documentation to arrive at an accurate diagnosis based on the medical evidence. The two Ombudsmen were not aware of the depth of FPS evaluations nor did they have a detailed understanding of how FPS providers arrived at

their diagnosis. From the Ombudsmen limited understanding of the FPS evaluation process, their perception was that FPS was making their diagnosis based on a one-time limited interview of the Soldier and the Soldier's responses to a questionnaire. This perception did not make sense to the Ombudsmen and in their attempt to understand and explain the reasons for FPS diagnosis of PTSD-no, they created the assumption that FPS must be using financial considerations in making their PTSD-no diagnosis.

5. **Findings.** I make the following findings by a preponderance of the evidence:

a. The prevailing command climate at MAMC created by (b)(6), particularly as it relates to Soldier care, is extremely positive and appropriate. The command climate is focused on building a values-based, standards driven, team which effectively provides world-class healthcare to Soldiers, family members, and retirees. A significant amount of command focus and effort is directed on improving healthcare delivery and access to Soldiers. (b)(6) is almost universally considered by everyone interviewed during this investigation as one of the, if not the, finest hospital commanders ever assigned to MAMC. (b)(6) command climate was accepted, endorsed and engrained throughout the command and was one of the driving factors behind the significant improvement in the effective delivery of healthcare at MAMC as measured by a number of metrics since (b)(6) assumed command.

b. (b)(6) did not inappropriately direct or influence the activities or development of diagnosis of the MAMC forensic psychology/psychiatry section (FPS) in the Army Physical Disability Evaluation Process. The evidence shows that the extent of (b)(6) influence and guidance to make accurate diagnosis based on the on the medical evidence using established medical standards within the field of psychiatry.

c. (b)(6) did not direct, mandate, or influence FPS providers to change diagnosis or conclusions of Post Traumatic Stress Disorder (PTSD) from PTSD-yes to PTSD-no, or to some similar conclusion during the APEDS process. The evidence shows that (b)(6) had no involvement whatsoever in any FPS cases until the fall of 2011 and then he only reviewed a few cases which had come to his attention thorough Congressional inquiries. In September 2011 he met with (b)(6) in an apparent effort to address her concerns about some of the diagnoses being rendered by some of the providers. (b)(6) reviewed some of the findings of the FPS, which he concurred with, and supported in all cases. Given that (b)(6) is not a psychiatric doctor, and that FPS diagnostic practices had been considered to be the most accurate,

it was reasonable for him to respond in the manner that he did; to review the matter and to defer to the FPS providers. This was especially appropriate given that (b)(6) is not a provider, does not have an FPS background, and that she not objective or credible in her dealings with providers.

d. (b)(6) played no role in enhancing the level of scrutiny or review applied by the FPS providers to PTSD diagnoses in APDES. The evidence shows that (b)(6) (b)(6) played no direct role in the level of scrutiny FPS used to evaluate cases of PTSD, other than to provide positive guidance to providers: That they should do what is right and make accurate diagnosis based on the on the medical evidence using established medical standards within the field of psychiatry.

6. Recommendations.

a. (b)(5)
(b)(5)

b. (b)(5)
(b)(5)

(b)(6)

DEPARTMENT OF THE ARMY
HEADQUARTERS, WESTERN REGIONAL MEDICAL COMMAND
BOX 339500, MAIL STOP 109
JOINT BASE LEWIS-MCCHORD, WA 98433-9500

REPLY TO
ATTENTION OF:

MCWR-JA

- 5 APR 2012

MEMORANDUM FOR RECORD

SUBJECT: Report of Investigation

1. I have reviewed the report of investigation (ROI) into the command climate at Madigan Army Medical Center and the issue of whether the commander improperly influenced the diagnoses or practices of the Forensic Psychiatry Section. I have considered the legal opinion concerning the sufficiency of the investigating officer's report.

2. The findings are approved. The recommendations are taken under advisement. In addition, the ROI will be provided to the US Army Medical Command and to the Acting Commander, MAMC, for consideration, collaboration, and implementation of the recommendations as appropriate.

Richard W Thomas

RICHARD W. THOMAS
Major General, USA
Commanding

DEPARTMENT OF THE ARMY
HEADQUARTERS, WESTERN REGIONAL MEDICAL COMMAND
BOX 339500, MAIL STOP 109
JOINT BASE LEWIS-MCCHORD, WASHINGTON 98433-9500

REPLY TO ATTENTION OF:

24 FEB 2012

MCWR-JA

MEMORANDUM FOR (b)(6) (b)(6)

SUBJECT: Appointment as Investigating Officer—Madigan Army Medical Center (MAMC)

1. UP AR 15-6, Procedures for Investigating Officers and Boards of Officers, 2 October 2006, you are hereby appointed to conduct an inquiry into the tenure of (b)(6) (b)(6) Commander, MAMC.

2. Your investigation should include, but not be limited to, clear findings of fact on these specific matters:

a. The prevailing command climate at MAMC during (b)(6) tenure, particularly as it relates to Soldier care;

b. The extent to which (b)(6) directed or influenced the activities of the MAMC forensic psychology/psychiatry section (FPS) in the Army Physical Disability Evaluation Process (APDES);

c. The extent to which (b)(6) directed, mandated, or influenced FPS providers to change diagnoses or conclusions of Post-Traumatic Stress Disorder (PTSD) from PTSD-yes to PTSD-no, or to some similar conclusion during the APDES process;

d. Whether (b)(6) played a role in enhancing the level of scrutiny or review applied by the FPS providers to PTSD diagnoses in APDES;

e. Whether (b)(6) directed or required that FPS providers use specific forensic psychiatry/psychology testing tools in assessing, confirming or changing PTSD diagnoses in APDES. Was (b)(6) aware, for example, of the psychometric testing tools being used in confirming or changing PTSD diagnoses in APDES? Was he aware of opposing views on the propriety of using such psychometric testing tools in all or nearly all PTSD cases in APDES?

f. The extent of (b)(6) involvement in ending the use of psychometric testing tools in assessing, confirming or changing PTSD diagnoses in APDES in approximately September 2011. Was this decision timely? What attention and

EX 3

command resources did he direct to making this decision in a timely manner (even if the decision was made by someone else)?

g. The extent to which (b)(6) made comments or decisions that indicate he improperly considered the long term cost of PTSD diagnoses.

3. To the fullest extent possible, you will make specific factual findings regarding these issues. Use AR 15-6, chapters 3 and 4, as a guide. Your findings should include, at a minimum, the matters specified above. You should also make any other findings necessary in the course of your duties. Cite the evidence that supports your findings. If there are conflicting statements or evidence, say whom you believe, and why. Your findings should be supported by a preponderance of the evidence in the record you develop.

4. Your investigation should include witness interviews with the appropriate personnel and any necessary technical witnesses you need to consult. Caution all witnesses they must not discuss the subject matter of the investigation with anyone other than a properly detailed investigator. In addition to making specific findings, you should also make specific recommendations for further actions based upon your findings.

5. This duty takes precedence over all other duties, including leave and TDY, until the investigation has been completed. Before beginning your investigation, make an appointment for a legal briefing with the Office of the Command Judge Advocate, Western Regional Medical Command, (b)(6) Before submitting your final report to me, obtain a legal review from that office.

6. Witness statements should be sworn and written on DA Form 2823, Sworn Statement, or equivalent. Provide all witnesses with a Privacy Act statement tailored to the circumstances of this case. (The legal advisor will assist you with these documents). Your final report, including findings and recommendations, must be submitted on DA Form 1574 NLT 5 March 2012.

7. If, in the course of your inquiry, you suspect that any person subject to the Uniform Code of Military Justice whom you are interviewing may have committed a criminal offense, use DA Form 3881, Rights Warning/Procedure Waiver Certificate, to advise the individual of his or her rights under Article 31, UCMJ. Consult with your legal advisor on this issue before proceeding with such an interview. If you suspect any individual has engaged in criminal misconduct, report that to me immediately.

MCWR-JA
SUBJECT: Appointment as Investigating Officer—Madigan Healthcare System

8. You may find it necessary to interview civilian employees. Generally speaking, federal civilian employees are required to cooperate with official investigations. There are some exceptions:

a. Civilian employees who are members of a bargaining unit have a right to union representation at any interview with management if they reasonably believe that the interview could result in disciplinary action against them. You have no obligation to arrange for representation; you must allow the employee a reasonable time (e.g., 24 hours) to secure representation. The Civilian Personnel Advisory Center can tell you whether any particular employee you wish to interview is a member of a bargaining unit.

b. Civilian employees who reasonably believe that information they provide during an official inquiry may be used against them in a criminal prosecution may not be required to cooperate without a grant of immunity. Should an employee you attempt to interview decline to cooperate because the employee fears the answers given will incriminate the employee, suspend the interview and seek guidance from your legal advisor.

c. If the matter you are investigating involves a grievance, a personnel practice or policy or other conditions of employment, you may be required to notify the union of any interviews you have scheduled with bargaining unit employees and afford the union the opportunity to be present. Check with your legal advisor to determine if this rule applies in your case and how to proceed if it does.

d. If your investigation indicates you should interview non-DoD civilian witnesses, consult with your legal advisor and appropriate officials before proceeding.

e. You have no authority to compel the cooperation of contractor employees. If you find it necessary to interview contract employees, you must contact the contracting officer's representative for the applicable contract to request cooperation.

9. You will consult with (b)(6) your legal advisor at the Office of the Command Judge Advocate (b)(6) immediately upon receipt of this appointment.

PHILIP VOLPE
Major General, USA
Commanding

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.

ROUTINE USES: Any information you provide may be disclosed to members of the Department of Defense (DoD) who have a need for the information in the performance of their official duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:

a. To members of the U.S. Department of Justice when necessary in the defense of litigation brought against the DoD, or against the members of that department as a result of actions taken in their official capacity.

b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

DISCLOSURE: If you are a military member or a federal employee being ordered to provide a statement to assist an official investigation, providing the information is mandatory. Failure to provide information could result in disciplinary action or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations.

If you are not a military member or a federal employee ordered to provide information, or if you reasonably believe that your information will incriminate you (that is, that you are reasonably likely to admit to criminal misconduct), disclosure is voluntary, and there will be no adverse effect on you for not furnishing the information other than that certain information might not otherwise be available to the commander for his or her decision in this matter.

1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/03 3. TIME 1400 4. FILE NUMBER ____
5. NAME (b)(6) 6. SSN 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS Madigan Army Medical Center

9. I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your duty position?
A: Currently, I am on administrative leave from being the commander of the Madigan Army Medical Center (MAMC).

Q: When did you assume command of MAMC?
A: 10 March 2011

Q: Prior to taking command of MAMC did you receive any guidance on areas that higher command wanted you to focus on, or issues to look at during your time in command?
A: Yes, prior to taking command at Madigan I was at the Western Regional Command where I was the Chief of Clinical Operations. In that position I was as able to see all 11 MTFs in the western region and how they were performing. Madigan was identified as the poorer performer as far as various metrics like fiscal solvency, access to care, funded-to-value ratio. General Volpe shared with me that his biggest concern at Madigan was the "barons," as he called them. Barons were individuals that had been at Madigan for decades that were comfortable in their positions and not necessarily working as hard as they could or should be working. My guidance in a nut shell was to get Madigan back on the right track, to ensure access to care was where it was supposed to be, and that we were more prudent on how we were delivering health care relative to the cost that Madigan represents to the Army.

Q: After taking command and assessing the situation at Madigan yourself, what did your assessment tell you about the state of Madigan and what you wanted to focus on?
A: Coming out of my job as the Chief of Clinical Operations I already knew what departments were not operating efficiently. I already knew what departments were not seeing patients on Fridays, for example. I already knew that we had doctors that were coming to work at 6 am and leaving at 2 am, even though clinic hours were from 8 am to 4 pm. So I came in with an agenda of restoring accountability for providers and discipline and focus on patient care rather than personal agenda.

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED

Ex. 4

9. STATEMENT *(Continued)*

Q: What was your attack plan, how did you go about doing all of that?
A: The first thing I did was have a commanders introduction and a commanders philosophy briefing in the auditorium a number of times, it was well attended and I have provided you with a video tape of one of the sessions. I have not reviewed that, so whoever recorded it, it is what it is. The brief focused on many things but one of the main points was that it is a privilege and an honor to deliver care to patients and that if it ever became a burden to a provider that (1) there was help available if they were experiencing "burn out." If they truly became burdened by the act of giving health care that they should probably pursue a different line of work. My vision for Madigan was to become a values-based, standards-driven team. I focused on three values, first being Integrity, we do what we say we are going to do; patients' lives depend on truth. My second value is Selflessness, again focus on the concept that it is an honor and privilege to do what we do, and owning the patient's problem. The third value is Duty. I expect a day's work for a day's wage and that everyone give it the best you've got while you are at work. Going over basic army standards with uniform, professional conduct, we should be standards-driven in everything we do. I wanted to see more collaborative approach in everything we did as a team. That is the core of my command philosophy. One of the past commander's focus areas was on winning the Baldrige Award. I was asked if we had a chance of winning the Baldrige Award, my response was not at this time. I discussed what that award meant and explained that no company that comes in $40 million in the red is going to win an award for "organizational process excellence." And then I would ask if we had the talent and can we win the Baldrige if we got our acts together and then I would say, "Absolutely, I have no doubt in my mind." That is how I chose to get after what needed to be done and attack the charge that MG Volpe had given me to get Madigan back on the right azimuth.

Q: After your mission and philosophy was put out, how were you as a commander going to get out and evaluate things and seeing how you could spread your influence throughout your command?
A: I would have meetings to discuss access to care, I would be briefed on any variety of metrics, and it would involve leadership from these departments that these metrics focused on. It was broken down to a very fine line of detail and even broken down to provider. So I would start asking the hard questions, such as, why does Dr. So and So not see patients on Fridays. It was a tough fight, people did not necessary embrace wanting to change especially changed that involved them working more. I wanted a day's work for a day's wage; that was my mantra. There were meetings daily, weekly, monthly to evaluate these metrics to see how we could do better. There was a lot of discussion on changing our policies, to better deliver care to our patient population. I would have town hall meetings with the command; we asked the command what was the best way for the commander to communicate with you. I offered Facebook, blogging, but in the end they wanted town hall meetings, they wanted to see my face. So we did, I hold 5 town hall meetings, every quarter.

Q: Fast forwarding to more recently, how do you self assess of where you are on that path and what if any indications did you have of how you were doing?
A: I'm actually very pleased with the progress we have been able to make at Madigan. If you were able to look at the multitude of metrics by which we are tracked, you would see that we have positive movement in virtually all of them. We have gone from being the worse in the AMEDD, to middle of the field in some, and in some metrics we lead the medical command. Recently, I received cash reward of 200,000 dollars from the Surgeon General because of growth in both inpatient and outpatient care. Outpatient care reported 16 – 18 % growth in the last 6 months and Inpatient has had a positive grown of 6%, which is huge; and we were award for that. At early town hall meetings, I found myself talking to stern faces and crossed arms. Now, when I deliver the same command message, people that are laughing and relaxed, and nodding in agreement with me. I think we have come a long way.

9. STATEMENT *(Continued)*

Q: Do you have any initiatives or anything related to Soldier care that you are particularly proud of?
A: That is my driving focus really. Battalion Aid station care is medic and PA operated. In a brigade that is lucky enough to have a brigade surgeon on their manning document, that surgeon can be more of a staff officer for the brigade commander than he is a provider of health care. Patient care can lack adequate oversight and continuity. The worst case scenario is that patients can be mismanaged. All of this can lead to Soldiers being medically not ready, and this is a problem of great concern in today's Army. My big push has been in managing Soldier care. I have pushed an agenda of creating the first Soldier Centered Medical Home. I believe there is a fundamental base plate of care that every Soldier needs. Of course, they need primary care, to handle minor illnesses. But, 80% of the Soldiers that go to their aid stations have musculo-skeletal complaints. Accordingly, aid stations need physical therapy. They need behavioral health care. They need nurse care management and finally, they need help navigating the disability evaluation system, which is very complex. To establish this base plate requirement of Soldier services, we are pushing assets from Madigan to fill whatever is missing in the brigade's manning document. At our first Soldier Centered Medical Home, we have pushed physical therapy, behavioral health, nurse care management, and PEBLOs and MEB techs down to the units in an effort to provide more timely, focused care for Soldiers. The ultimate goal is to increase a Soldier's readiness and with that, the unit's readiness. We briefed our initiative to the FORSCOM DCG. In his trip report to the VCSA, he said, "This initiative has the potential to transform the face of Soldier care across the force." My other focus has been on the Sports Medicine Department that I have established at one of the gyms on post. This initiative offers fellowship level trained providers in sports medicine directed at Soldiers that need a level of care above their local unit level, and they can get that high level of care without having to come inside Madigan. Another focus area for me centers on my concern about abuse of prescription narcotics in the force. I know from my time with the line, there are some Soldiers carrying bottles with hundreds of pills in their cargo pockets. We have made a concerted effort to stand up an Inter-disciplinary Pain Management Department, which incorporates alternative and complementary medicine modalities, all in an effort to reduce the amount of narcotics prescribed to and used by our Soldiers.

Q: When did you first become aware that there was any type of issue or discontent with the evaluations that FPS was giving to Soldiers as they were going through the disability process.
A: I don't recall exactly, but I believe it was late summer /early fall of 2011 (July – August). (b)(6) had come on board as the new deputy commander of clinical services and she first brought it to my attention that there were issues with variance in diagnosis of PTSD, particularly between the VA providers and the Madigan providers.

Q: When you learned of this issue what did you do?
A: I spoke with (b)(6) and with Department of Behavioral health. One of the things we were trying to do was move from a stove piped behavioral health department to more of a consolidated interdisciplinary program, by bringing the various disparate departments under one umbrella, a consolidated Department of Behavioral Health. We thought through this approach we would be better suited to come to correct diagnoses and offer better treatment plans for Soldiers and families. I met with (b)(6) the Chief of FPS, and he shared their process of how they were evaluating Soldiers with various behavioral health diagnoses, including PTSD. He laid their process out for me - the data points they looked for; they do records reviews, they use psychological testing as they deem appropriate, they meet face to face with the Solider, they contact the Soldier's chain of command, they communicate with the family, and then they pull all of that together and make their diagnosis. I felt the approach to be comprehensive. I was briefed that MAMC FPS's process was in keeping with the standards of care for the American Psychological Association and the American Academy of Psychiatry. It seems like a very complete and appropriate method to arrive at a diagnosis. I was then told that

9. STATEMENT *(Continued)*

there were a few Soldiers that were unhappy that they were not given the diagnosis of PTSD, and that there were even some death threats being made against the FPS providers. I really did not understand why someone would offer a death threat against a doctor because they had not been diagnosed with PTSD. An ombudsman's name kept coming up as enflaming the issue. I did not understand what was going on, so I met with (b)(6) (b)(6) (b)(6) the second ombudsman, and with (b)(6) in my office to get a better understanding of the situation. At that meeting (b)(6) was very vocal, tearful, and frustrated, obviously passionate about the Soldiers she was working with. The issue was that the Soldiers had been told somewhere along their career path that they had PTSD, some by psychiatrists, primary care providers, physician assistance, nurses, what have you, throughout their career. Then they were told by FPS that they did not have PTSD. (b)(6) was angry that these psychiatrists were holding themselves up as experts in the field and that their diagnosis was the most accurate. I shared with her that these psychiatrists had gone through years of training and that I was familiar with their approach and that to me, it did seem comprehensive and in line with the guidelines and standards of care by the governing body of knowledge. The fact that they had devoted their lives to this field of study did in a way, make them experts in the field, more so that a primary care provider or physician's assistant or a nurse practitioner. I offered that if I had cancer, I would take the advice of an oncologist over the advice of my regular provider. She seemed ok with that discussion, somewhat appeased. However she did think a system needed to be put in place so that Soldiers were not led to believe that they had a diagnosis by an unqualified provider. I agreed with her that a policy needed to come out from MEDCOM that limited the scope of who could put a diagnosis of PTSD in a patient's chart. I thought the meeting went pretty well and that was the only time I met with the ombudsman.

Q: Did you ever issue any guidance to any of the behavioral health providers in what you expected them to use as criteria for evaluating Soldiers they saw?
A: Absolutely not. I wouldn't even pretend to have any knowledge or expertise in the practice of their specialty. I would never tell them how to do their business. Just as I would not expect them to tell me how to practice my specialty in medicine.

Q: Are you aware if FPS providers considered financial costs to the government when considering their diagnosis of PTSD?
A: I became aware of that concern when it hit the press, because (b)(6) had sent up her Memorandum for Record concerning an educational briefing that had occurred. (b)(6) had given a presentation to the WTB leadership, the ombudsmen, some social workers, and nurses on forensic psychiatry, in an effort to bring everyone on the same sheet of music. In the course of that briefing, he had a couple of slides that spoke to the potential financial benefit of being diagnosed with PTSD. My understanding of that briefing is that it lasted about 30 minutes. The time spent on the financial aspect was less than one minute, although that was the focus of (b)(6) Memorandum for Record. This is the focus of several newspaper articles that later appeared in the press. I have come to understand that it is a requirement within forensic psychiatry's standard of care to consider all matters that could bear on an individual's diagnosis. Thinking about (b)(6) briefing to me on how they arrive at a diagnosis - hat they would do the comprehensive chart review, that they would talk to the commander, that they would speak to the spouse, that they would do psychometric testing, that they would spend hours interviewing a Soldier, and then piecing it all together. Their specialty requires that they be able to defend their opinion or diagnosis in a court of law when it comes to a given individual's case. So, they must consider all internal and external factors coming to bear on a Soldier. One of those things must be consideration of potential financial gain. I was unaware of this, but apparently upwards of 1.5 million dollars in lifetime benefits can be gained from having this diagnosis which could incentivize a Soldier to claim PTSD. So, the

9. STATEMENT *(Continued)*

standard of practice for forensic psychiatry is to consider that and whether or not that external incentive is playing a role in the patient's presentation. It makes perfect sense to me that that would be the case.

Q: Are you aware of any FPS providers downgrading a Soldiers diagnosis of PTSD in order to save the government?
A: No. Absolutely not. I believe FPS follows the diagnostic criteria and standards of care outlined by their specialty.

Q: Did you issue any guidance to (b)(6) or any of the FPS providers to consider financial costs to the government in rendering a diagnosis of PTSD?
A: Absolutely not. Never.

Q: Did you have occasion to dig into the metrics of FPS cases?
A: When this first started to break loose there were a couple of cases that were pretty prevalent. One of these cases had already made it to the Secretary of the Army level. I was uncertain of how it happened and I was unaware of it prior to hitting the SEC Army's office and now I was hearing about it top down. I reviewed that case in some detail with (b)(6) and came away from that meeting comfortable that they had arrived at the correct diagnosis, which was not PTSD. Similarly, I looked at three or four other cases that were breaking loose at levels outside of the command and again, felt comfortable that the providers had done due diligence and arrived at the correct diagnosis. Admittedly, I am not a psychiatrist, but I felt comfortable with their process and did not feel that the FPS providers were making diagnoses inappropriately.

Q: Did you get any inclination that anyone in FPS was using the high financial cost to the government to downgrade a diagnosis of PTSD?
A: No. That was not brought up in any of my discussions or reviews. To my knowledge the only time that was brought up was in the 1 September educational briefing of (b)(6) That concept was mentioned, it was less than one minute of his briefing, it is clearly being blown out of proportion and used to attack (b)(6) and his team. I have not seen any evidence that concern over saving government money is a driver of arriving or not arriving at a diagnosis.

Q: Is there further that you wish to say?
A: Two things. One, I think it is very interesting that FPS has come under scrutiny for not diagnosing PTSD. I think that if we look at the data, we would find that PTSD is actually the most commonly diagnosed condition coming out of our behavioral health department, by a fairly significant margin. At the same time that the 14 Soldiers were not diagnosed with PTSD, at least 44 other Soldiers that entered the disability evaluation system without a diagnosis of PTSD, were actually diagnosed with PTSD. If this were about saving money, this section has failed miserably. They made the diagnosis of PTSD in hundreds of cases, even in dozens of cases where the Soldiers did not think they had PTSD. My second point is about command climate. I talked early on when I took command about the gap between the civilian and uniformed workforce and one of my focus areas is on everyone being a team - many hands make light work, and how to thrive in an era of fiscal constraint, budget cuts, and hiring freezes. I would say that based on the outpouring of support that I have received, my wife has received, from both civilian and uniformed members of the command; that this whole circumstance has really pulled the team together. I have received letters of support from all walks of the command, including patients, which is very heartening to see. So, I think the command climate is good. We will get through this.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/02

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 5. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Signature of Person Making Statement)

WITNESSES

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 12 day of March, 2012 at Joint Base Lewis McChord, Washington

(b)(6)

(Authority to Administer Oaths)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/02 3. TIME 0900 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC, JBLM

9.
I (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your position here at Madigan?
A: I am the Chief of the Forensic Psychiatry/ Behavioral Health Service.

Q: What are the criteria that FPS uses to determine if a Soldier's diagnosis of PTSD is correct?
A: We use the diagnostic and statistical manual of mental health disorders, the DSM4TR. It is the most recent version.

Q: Is that a national standard?
A: Yes. It's the "Gold Standard" according to Army regulation and UCMJ.

Q: What is the Army regulation?
A: I believe it is in AR 40-400 Chapter 7. It is also in the UCMJ.

Q: Is that the national standard?
A: Actually it is the international standard on how to make an psychiatric diagnosis. It's the book. It's the diagnostic manual for mental illness.

Q: What are the criteria that you look at when evaluating a Soldier for PTSD according to this manual?
A: The first step is to understand the referral question. What are they asking for. Once you figure out what they are asking, you review the information provided. Which is going to be a consultation report, a provisional diagnosis, the medical record, selected personnel documents filled out by the chain of command, and maybe medical information from the VA system, maybe their counseling packet, and sometimes sworn statements. You look at all the information that is available, then we meet the patient and do a structured mental health patient interview. Who they are; what is their complaint; what is their demographic information; what are they experiencing; what are they not experiencing;, and then you do a bio-psycho formulation. But for PTSD what you are looking for is was the patient exposed to a physical trauma severe enough to meet the criteria 1A of the

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED

Ex. 5

9. STATEMENT *(Continued)*

diagnosis of PTSD in the manual. That is criteria one has two parts; was there a trauma and (b) was there a certain kind of reaction to the trauma, fear, hopelessness, horror that is criteria one. Criteria two is that the patient persistently re-experiencing the trauma in form of nightmares, intrusive thoughts, or dissociative events, flashbacks. That is criteria two. Criteria three is persistent avoidance. Are they avoiding things in the environment, conversations, emotions, are they isolating from people. In the context of the trauma they are re-experiencing. The forth criteria is persistent arousal. Irritability directly related to the experience. Hyper-vigilance to their environment. That's criteria four. Five is the functional impairment that is interfering with significant sphere of life relationships (work, school things like that). Then there are time criteria, how long has it lasted? The symptoms you are observing in the patient are not better accounted for by a different mental illness. Those are roughly the criteria, and that's what the diagnosis requires. That's what we look for. We look for that in the documentation, we look for that in the report of the patient, and sometimes we administer psychometric tests which produce a scale. We don't always use those tests. They are a data element that is sometimes useful in a given case. The providers that do this work administer the tests when they are clinically indicated, but not all the time. After we collect all that, after we see the patient, after we do whatever testing is required, we then contact additional sources of information. Sometimes the patient will give us phone numbers or letters or sworn statements, or copies of their awards. We take all of that information and compare that to not only the PTSD diagnosis but all of the diagnosis in the manual. We formulate an opinion as to what is the most accurate diagnosis and then we write or report orally on our opinion depending on what the referral question is. That's the process.

Q: Do you consider financial costs to the government of a diagnosis of PTSD in rendering your opinion?
A: That's has never been a consideration.

Q: Are you aware of any FPS providers considering financial costs to the government of a diagnosis of PTSD in rendering their opinion?
A: No.

Q. Did (b)(6) directed providers to consider criteria beyond the regulation and medical standards that you have explained to me in conducting their evaluations?
A: In my conversations with him he specifically never did that. I know that. I have absolutely no indications or suspicions that absent of me witnessing it he never did it with anybody else.

Q: Are you aware of any meetings that (b)(6) ever had where he issued any guidance of what he expected of the FPS providers in reviewing cases and issue opinions?
A: We have met and the guidance from him was to be accurate and base our diagnosis on the medical evidence and do good hard work. That's the only guidance he has given us.

Q: What has been your guidance to the FPS providers?
A: Exactly the same. Follow your training, base your decisions on the medical evidence, and use the standards that are defined in our profession the DSM4, Army regulation, policy from the Office of the Surgeon General, guidance from the U.S. Army physical disability agency. That's it.

Q: Did (b)(6) ever issue any guidance to use any criteria other than the standards, specifically finical costs to the government, when rendering your diagnosis.
A: No. (b)(6) hired me to do the work according to the professional training and standards and to make our diagnosis based on the medical evidence.

9. STATEMENT *(Continued)*

Q: In the 1 September 2011 lecture you gave to selected WTB staff and others did you ever refer to the cost to the government of a diagnosis of PTSD.
A: I don't believe I did. I do believe that I mentioned the cost to the tax payer of a medical board, but nothing about a specific type of medical board for a specific condition. The purpose was just to bring attention to the audience of the importance of making good, accurate clinical, diagnosis based on the medical evidence. It is not arbitrary it has significance. That statement was never intended to be taken out of that context.

Q: What was the message you were trying to deliver?
A: Transparency of process, collaboration of effort, and facilitation of communication. I believe I used those words or words to that effect. I was a new employee; I had only been back for less than 90 days when I gave this lecture. I had been gone from the service for 18 months and there seemed to have developed some sort of tension that was not there when I left. (b)(6) had noticed this tension and she asked me to build a better collaborative effort with our colleagues in the WTB. That's was the objectives of the lecture was and what I showed them. I went into all of it. How we do it; why we do it; what the standards are; what the responsibilities are: what we owe the Soldiers, what our process is. The goal was for them to understand what we do and how we do it so we could work better together for the benefit of the Soldier.

Q: Did anyone in the Madigan chain of command issue any guidance for you or your providers to use financial costs to the government in your consideration of PTSD?
A: No, never.

Q: Did anyone in the Madigan chain of command issue any guidance for you or your providers to use anything other than the appropriate regular criteria you have laid out in your consideration of PTSD?
A: No, never.

Q: How would you describe the command climate that (b)(6) was attempting to create relative FPS doing its job?
A: I think that his leadership style and tone was firm, fare, and respectful.

Q: Do you have a basis of comparison of command climates of commanders at Madigan while you have been assigned here while on active duty and now as a civilian.
A: I was here under General Baxter's command, General Horahos command, (b)(6) command, and now under (b)(6) command. (b)(6) is the most dynamic of the Madigan commander's I have served with. I was given the most information from the commander under (b)(6). I have learned a lot from (b)(6). I learned a lot of the issue that were important to Madigan, accountability of time, relative value units, productivity and I thought it was good information to have and I followed his guidance.

Q: What messages did you take away from (b)(6) town hall meetings relative to Soldier care?
A: Never compromise Soldier care.

Q: What was the effect of (b)(6) command climate on the impact of delivery of Soldier Care?
A: The only impact that I am aware of is it improved the staffs understanding of the importance of documenting the care we provide, being accountable for our time, and practicing the best that we can within the scope of our practices.

Q: Do you have anything further to add?

9. STATEMENT *(Continued)*

A: I don't think (b)(6) had any negative influences on the FPS section.\

----------NOTHING FOLLOWS----------

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 4. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Signature of Person Making Statement)

WITNESSES

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 9 day of MARCH, 2012 at Joint Base Lewis McChord, Washington

(b)(6)

(Authority to Administer Oaths)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.

ROUTINE USES: Any information you provide may be disclosed to members of the Department of Defense (DoD) who have a need for the information in the performance of their official duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:

a. To members of the U.S. Department of Justice when necessary in the defense of litigation brought against the DoD, or against the members of that department as a result of actions taken in their official capacity.

b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

DISCLOSURE: If you are a military member or a federal employee being ordered to provide a statement to assist an official investigation, providing the information is mandatory. Failure to provide information could result in disciplinary action or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations.

If you are not a military member or a federal employee ordered to provide information, or if you reasonably believe that your information will incriminate you (that is, that you are reasonably likely to admit to criminal misconduct), disclosure is voluntary, and there will be no adverse effect on you for not furnishing the information other than that certain information might not otherwise be available to the commander for his or her decision in this matter.

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/02/27 3. TIME 1500 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC, JBLM

9.

(b)(6) I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your job?
A: I am the Deputy Commander for Administration / Chief of Staff.

Q: What are the criteria considered in rendering a PTSD diagnosis during the disability evaluation system?
A: The MEB process belongs to the Deputy Commander for Clinical Services not me. I am responsible for some of the people who execute the process but I do not direct the process. That belongs to the DCCS.

Q: How would you describe the command climate that (b)(6) has created at Madigan?
A: He has created an extremely good command climate. He loves Soldiers and Madigan employees. He loves taking care of Soldiers, patients, and employees. He cares more about Soldiers than any other commander I have served with. Just look at his Soldier Centered Medical Home initiative. He has taken this on at great risk to himself as a commander by implementing the project without financial backing in time of budget cuts. I think he is one of the best hospital commanders in the Army today.

Q: Are you aware of any influence, guidance, or directives (b)(6) gave to FPS in diagnosis PTSD?
A: No, I am not. Having said that, I can't imagine that he would try to influence a diagnosis of any sort. In my career, I have never seen one physician try to influence the diagnosis of another provider.

Q: How has Madigan preformed under the command of (b)(6) ?
A: Since taking command (b)(6) has significantly improved the quality of care to Soldiers. He has improved the accountability and effectiveness of our delivery of care, and across the board, numerous measures and statics have continuously improved during his command. I cannot over emphasize what a quality commander (b)(6) is. (b)(6)

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10. EXHIBIT _____ 11. INITIALS OF PERSON MAKING STATEMENT (b)(6) PAGE 1 OF 2 PAGES

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED

EA.6

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/02/27

9. STATEMENT *(Continued)*

The statement continues on until the end. **NOTHING FOLLOWS.**

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING [illegible] THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REV[illegible]ENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR [illegible]

(b)(6)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 9 day of MARCH, 2012 at Joint Base Lewis McChord Washington

(b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT (b)(6)

SWORN STATEMENT

PRIVACY ACT STATEMENT

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/02/28 3. TIME 1200 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC

9. I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: When were you the WTB surgeon?
A: From October 2008 through September 2011.

Q: How were you involved with the forensic psychiatry department's evaluation of soldier's diagnosis of PTSD?
A: My role was strictly as a reporter and the person who distributes the diagnosis that a specialist has made. If a soldier had a problem with is diagnosis then frequently we would have what we call a care conference. Often I was the one discussing the diagnosis that we read from the chart (e.g. this is what has been found, and these are the reasons why it has been found.)

Q: Were you aware of soldiers and cases that were going before FPS for review?
A: As the WTB surgeon, the group that I know is limited to the soldiers who are either complaining they were not getting the diagnosis that they want or they are displeased with the diagnosis they received. It could also be that there was a concern by the primary care team that something more serious was going on and because I had a good rapport with FPS I would be able to knock on the door and speed the process up to get them seen in a timely manner.

Q: Are you familiar with the process the FPS uses to evaluate soldiers for PTSD?
A: The evaluation is very time intensive. It's upward of 4 hours of chart review, to include any and all notes in the soldier's records, then a 1 to 2 hour evaluation with the soldier and a 2-4 hour dictation of these findings. It fills the role of a second opinion. There was a concern that soldiers were requesting a second FPS opinion which can lead to bias in the diagnosis. What I have read is an extensive history, physical examination section, then a very detailed write up by the people who do psychometric testing, and final section where FPS renders their diagnosis. FPS documents can be upwards of 20 pages long. I have above average of the FPS evaluation process.

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED

EX. 7

9. STATEMENT *(Continued)*

Q: Are you aware of any FPS providers considering financial compensation as criteria in determining a diagnosis of PTSD?
A: No. Their findings are based on good medical documentation; money does not play a role at all.

Q: How would you characterize your relationship and contact with (b)(6)?
A: Excellent. I thought he was a great commander, I knew that he spoke the truth, I thought he was a very fair commander, but a very demanding commander, but there is nothing wrong with that.

Q: What was your routine contact with (b)(6)?
A: I only met him occasionally. He had no influence in any way regarding medical board evaluations or FPS outcomes.

Q: Do you know if (b)(6) directed FPS providers to consider any criteria other than the standard medically expected criteria for FPS evaluation?
A: I don't have any knowledge of that at all. My experience with (b)(6) while he was in command is that he had no interaction with the FPS department influencing either way.

Q: Are you aware of any influence (b)(6) had on the FPS providers in making diagnosis of PTSD one way or the other?
A: None. Given (b)(6) background and professional standards, I would have difficulty believing he would attempt to influence any other provider's diagnoses. I have the same reservations that (b)(6) would allow the FPS to bow to any pressure.

Q: Would you be a position to know that, had he done it?
A: No.

Q: Were you present at the 1 September 2011 meeting between (b)(6) and several of the social workers of WTB?
A: I ran the meeting. I was still the WTB Surgeon and in charge of Clinical Operations.

Q: Why did you call the meeting?
A: Through the summer of 2011, there was a concern from social workers and some nurse case managers at the WTB that FPS was under-diagnosing PTSD. There was an ongoing request for second opinions for the FPS evaluations. I discussed this issue with (b)(6) and (b)(6) in an August 2011 meeting. The thinking at the time was the FPS evaluation was a second opinion. In order to bring everyone on the same page of understanding we decided to have the 1 September 2011 meeting. (b)(6) gave an excellent lecture. (b)(6) (b)(6) opened his lecture with an icebreaker type question, "Do you know how much an incorrect diagnosis of PTSD cost the government?" His slides indicated a cost somewhere between $400,000 and 1.5 million dollars. His key point was that we have to be responsible providers and we just can't rubber stamp what other people have said before if the medical record does not substantiate the diagnosis. Part of the lecture was to educate everyone as to the FPS evaluation process.

Q: Did (b)(6) comments on cost lead you to have the perception that the FPS was using cost as a factor in diagnosing PTSD?
A: No. (b)(6) and all of his FPS staff are excellent providers. I did not get any impression that cost played any role in their evaluation.

9. STATEMENT *(Continued)*

Q: What was your perception in introducing cost in his lecture?
A: I think it was just an icebreaker, something to catch your attention. It's important for us to do the right thing because it's the right thing to do. There are consequences to just rubber stamping a diagnosis and not doing good and proper medical evaluations.

Q: Did you notify (b)(6) that everyone was not on the same sheet of music?
A: I cannot recall. (b)(6) knew this, and she may have discussed it with (b)(6).

Q: Did you notify (b)(6) that everyone was not on the same sheet of music?
A: Yes. She was at the original meeting in which (b)(6) and I discussed this concern. She did not attend the meeting of 1 Sept 2011.

Q: Are you aware of any meetings that (b)(6) or (b)(6) had with FPS subsequent to the 1 September 2011?
A: No. I don't have any knowledge of any meetings at all.

Q: How would you describe (b)(6) command climate?
A: I mean this as a compliment, (b)(6) is known as a stickler. He is an admitted hard ass. People were initially concerned that things were going to be more problematic and challenging under his command but that turned out not to be true. I really enjoyed working for him. My wife also works at the hospital and has found working for him very rewarding.

Q: How would you describe (b)(6) command climate towards Soldier care?
A: He is patient-centered, his philosophy is care with compassion. He means what he says.

Q: Did you ever see any evidence of (b)(6) putting pressure on providers to use cost factors in rendering medical diagnosis?
A: No. Nothing of the sorts.

Q: Do you have anything further to add?
A: There is a general feeling that there is pressure from outside of JBLM to make the diagnosis of PTSD even though it is not necessarily there.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/02/28

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Signature of Person Making Statement)

WITNESSES

St
to
Jo

(b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/02/28 3. TIME 1220 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS WTB, JBLM

9.
I, (b)(6), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your duty position?
A: I am the Warrior Transition Battalion surgeon since August of 2011. I assumed the position from (b)(6) (b)(6)

Q: Do you have occasion to interface with the Forensic Psychiatric Section (FPS)?
A: I have, but not as a routine part of business. More when a problem comes up. Prior to me assuming duties as WTB surgeon there was a lot of issues between the WTB social workers and the behavioral health community at Madigan. Part of that was with FPS. On occasion, we would do care conferences to explain to Soldiers their FPS results. I also had some contact with (b)(6) the head of FPS, to attempt to try and get a better working relationship between the FPS and the WTB social worker team.

Q: Who are you referring to when you say social worker team?
A: We have group of social workers in the WTB who have a certain doctrinal job which is different than what they have been doing, and I believe this is a source of a lot of the conflict that I understand has been brewing now for a couple of years between behavioral health and social workers. My dealing with FPS was in part to make this relationship better. We have soldiers' in this program for a year or more and the social workers are telling them they have PTSD, PTSD, PTSD. They go to FPS to get the fit for duty evaluation, and FPS tells them no you don't have PTSD instead you have this or that. There in-lies the conflict.

Q: Do you characterize the MEDCOM ombudsman as social workers?
A: No. I have nothing to do with them although they do come to meetings. They do not work for WTB.

Q: Describe your level of knowledge of the criteria and process that FPS uses to determine if a Soldier has PTSD?
A: I have reviewed some of the FPS reports in preparation for care conferences. So I have read a couple of them in-depth. In my position as a physician I can say FPS' diagnosis are quiet in-depth and pretty straight forward

9. STATEMENT *(Continued)*

on how they reach to their conclusions. So I would say, I have a working knowledge of the FPS process. Quite often what you would hear from the soldier was, "How does Dr. So-and-So know? They only talked to me for an hour or an hour and a half." Well the interview is only a very small part of the entire evaluation and you can see that when you read one of the final reports. It will tell you how much time they spent on the report, what they did, they go over all the records, they analyze everything. What they don't do is question the Soldier's explanation of the original event. It is taken at face value.

Q: Are you aware of FPS providers using financial cost to the government as a criteria in determining their diagnosis of PTSD?
A: No.

Q: What is your relationship with the hospital commander, (b)(6) ?
A: I think he is my senior rater. He is two levels removed from me. I have only interfaced with him once.

Q: Are you aware of any involvement, direction, or guidance that (b)(6) has or had with FPS in their diagnosis of PTSD?
A: I have absolutely no knowledge of that.

Q: What do you believe (b)(6) meant when he stated at the 1 September 2011 meeting that an incorrect diagnosis of PTSD could cost the government up to 1.5 million dollars?
A: I took it as nothing more than we have to get things right. There are consequences for what we do. It is important that we get it right. We are supposed to be doing the right thing. I took it simply as an example of the consequences for not doing what is right. Not that money is a criteria in any way shape or form for determining PTSD. At the time of that lecture I didn't know the names of players. I didn't know what was going on, or much of the background. I think myself as a disinterested party. I did not have an axe to grind like many people in the room did as I have come to find out. My interpretation was just that we have to get things right. The money was just an example of the consequences of not getting it right.

Q: How would you describe (b)(6) command climate relative to Soldier care?
A: I don't perceive any type of bad command climate. I have been to one meeting where (b)(6) talked to all the department heads in the theater. He was very positive. I know the one before that was not so nice. I heard he was holding peoples feet to the fire to do their job. He was trying to improve things around here. As far as I know the command climate around here is fine.

Q: Do you have anything further to say?
A: I am not aware of any influence by (b)(6) on the outcome of FPS diagnosis at all. All FPS is doing is trying to get the diagnosis right by the tests they give Soldiers, what is supported in the record, what is support by all the evidence, and it's not up to FPS to make a decision on disability or compensation, that's the MEB/PEB process. FPS is there to look at the record as a disinterested party, does the evidence support the diagnosis within the criteria. From my discussions with (b)(6) he has this same attitude. I don't perceive that financial consideration or disability ratings have anything to do with it. Maybe it was a poor decision by (b)(6) (b)(6) to give an example of what a wrong diagnosis would end up costing the government, but I certainly do not think it proves a conspiracy to save the tax payer money. I don't believe that's the case at all.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/02/28

9. STATEMENT *(Continued)*

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(b)(6)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths this 15 day of MAR 2012 at (b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT (b)(6)

SWORN STATEMENT

PRIVACY ACT STATEMENT

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/02 3. TIME 1100 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC, JBLM

9.
I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: State your name and duty position.
A: (b)(6) I am the Deputy Chief for the Department of Behavioral Health, for the last five months. We reorganized the departments of psychiatry, psychology, social work, and child and family assistance center into a department of Behavioral Health in October of 2005. Previous to the reorganization I was the Deputy chief of the Department of Psychaitry 2008 – Oct 2011. Then I took over as the Chief of the Department of Psychiatry. Then in 1 January 2011 I officially assumed duties as the deputy of Behavioral Health but effectively I was performing the Deputy duties during the entire time of the reorganization.

Q: In your duty positions that you just described, would you say that you have a understanding of the criteria that the FPS section uses in evaluating Soldiers when rendering diagnosis of PTSD?
A: Absolutely.

Q: Can you explain to me in layman's terms generally what is the criteria that FPS uses to make those evaluations?
A: FPS is separate from the treating lane. We have a treating lane which is a treatment provider that provides treatment to patients. Standards in the IDES (Integrated Disability System) have outlined that the evaluator for disability benefits should be different than treatment provider to eliminate the possibility of bias. When the Soldier is seen by the FPS providers there is a comprehensive evaluation that is done. That evaluation includes a medical record review, it includes psychological testing as an objective measure as psychological testing and is part of standards for conducting these types of evaluations in the medical community, a comprehensive clinical interview in some cases that can last hours, they use collateral statements from commanders or people in their unit, and if needed they would use their ERB or other information from their personnel file, and if needed they would have a verbal discussion with the treating provider to clarify any questions. So it really is a multifaceted very comprehensive evaluation that relies on multiple data points.

Q: Are those criteria prescribed?

9. STATEMENT *(Continued)*

A: Yes. They are prescribed.

Q: Who are they prescribed by?
A: those are prescribed by professional organizations that guide the forensic specialty within American Psychological Association, American Psychiatric Association. Within that there are specifics that look at forensic type of work. So there are professional guidelines essentially, and then there is MEDCOM policy that talks about the use of psychological testing and in utilizing that in MEB evaluations. MEDCOM policy 11-76 outlines those guidelines. I believe also policy by the physical disability administration, U.S. Army Physical Disability Administration, as well as V.A. policy as well as IDES policy. And army regulations talks about using all data, comprehensive data in these evaluation.

Q: Are you aware of any directives in these bodies of policy's and instruction that would lead FPS that they need to take in account the financial cost to the government of what one of their diagnosis would cost?
A: Absolutely not. The sole focus on the FPS services is to provide a clinical accurate diagnosis, to make sure that service members are getting their prescribed treatment and any benefits they are entitled to based off that diagnosis.

Q: Are you aware of any FPS providers considering financial cost in rendering their diagnosis of PTSD?
A: Absolutely not. Again focus has always been on clinical accuracy.

Q: Do you believe in your duty position that it is likely that you would know if any providers would be using financial cost as criteria.
A: I would say it is very reasonable that I would know if they were using that as a criteria.

Q: Do you know if (b)(6) ever directed the FPS leaders to use any criteria other than the one you have described as the professional standards in doing their evaluations?
A: No. In fact it's quite the contrary. (b)(6) supported FPS and what they were doing, and was not asking them to practice sub-standard medicine.

Q: Are you aware of any guidance that (b)(6) ever gave, relative to the FPS evaluation of Soldiers, to either the Chief of Behavior Health or to (b)(6) ?
A: No I am not aware of any. No guidance, only support of how we were doing our process.

Q: Did (b)(6) actively influence the consideration of any non-medical, for example financial cost, to FPS and their care to Soldiers.
A: Absolutely not.

Q: Focusing on command climate, how would you in your position describe the command climate relative to duty performance and Soldier care that (b)(6) has attempted to create?
A: I think (b)(6) has created an environment of accountability and encouraged quality Soldier care; it has been his top priority. And you can tell that by some of the initiatives he has implemented since he has been here. Most strikingly is the Solider Centered Medical Home and in taking care to Soldiers. Where there is a potential rub is where the accountability that he established with the staff.

Q: What do you mean by potential rub?

9. STATEMENT *(Continued)*

A: He had expectations that were not unreasonable and when people were not accountable to those expectations he addressed that. And he addressed in a large forum. I was not there as I just returned from a deployment, so I wasn't there but I clearly heard about what had happened. My perception of that was that great, someone is holding us accountable, we need to be held accountable for some of these issues such as fiscal issues, not getting simple things like time cards done and not having them turned in on time.

Q: Would you say that he was doing something that was reasonable for a commander to do?
A: I think it was absolutely reasonable for a commander to do, and I think that over time as I attended his Thursday commanders reports and the subject of those meeting was business but he would quite frequently take the opportunity to discuss leadership, leadership techniques and dialog with leaders of the organizations, and grooming and mentoring in those particular situations.

Q: How would you describe your opinion of (b)(6) tenor as commander?
A: I have been through 4 commanders, he by far has been the most dynamic, and someone I would follow anywhere.

Q: Are you aware of any numbers or data of how many cases that the FPS keeps that says, "No you do not have PTSD"?
A: I am aware of that, yes.

Q: Can you give me an idea of what those numbers look like?
A: Sure, I looked specifically at it at the initiation of this whole issue, we were tasked by region to go back and do a report focusing on the MEB and the fitness for duty evaluations. We were able to extrapolate 1468 cases. Out of those 1468 cases there were I believe 431 cases a had received PTSD diagnosis from FPS and roughly well over 320-330 cases of the 431 cases that failed to meet retention standards. There are a percentage of those that didn't want to be boarded that wanted to return to duty.

Q: I am more interested in the data on how many Soldiers that went before FPS that were said to have been diagnosed with PTSD and FPS overturned that diagnosis and the number of Soldiers that did not have a diagnosis of PTSD and then FPS said that they did in fact have PTSD.
A: I have incomplete numbers but I can share with you what I do have. I focused on the adjustment disorder diagnosis, so what I did is a review of 224 or so diagnosis that came from FPS or that was FPS final diagnosis. I ended up personally looking at 194 of those 224 cases because I ran out time to look at all of them and what I was looking for was just that, who had a pre-existing diagnosis of PTSD and left FPS with the diagnosis of adjustment disorder. The number was roughly in the low 80s, so 80 of the 194, less than half of the cases I reviewed had a diagnosis of PTSD in the medical record somewhere and then left FPS with the diagnosis of adjustment disorder diagnosis. I did see some data that there were about 44 cases that went to FPS that didn't have a diagnosis of PTSD but left with a diagnosis of PTSD. In addition there were several other cases that did not have a diagnosis, a disqualifying diagnosis prior to FPS and received a disqualifying diagnosis after they left FPS.

Q: Relative to the command climate for (b)(6) and any inappropriate influence he may have had, do you have anything further to add?
Q: No Sir.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/02

9. STATEMENT *(Continued)*

I (b)(6), HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 4. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Taking Statement)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 1st day of March, 2012 at (b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).
PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.
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b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.
DISCLOSURE: If you are a military member or a federal employee being ordered to provide a statement to assist an official investigation, providing the information is mandatory. Failure to provide information could result in disciplinary action or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations.
If you are not a military member or a federal employee ordered to provide information, or if you reasonably believe that your information will incriminate you (that is, that you are reasonably likely to admit to criminal misconduct), disclosure is voluntary, and there will be no adverse effect on you for not furnishing the information other than that certain information might not otherwise be available to the commander for his or her decision in this matter.

1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/05 3. TIME 0900 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS WTB, JBLM

9.
I (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your duty position?
A: I am the Chief of Clinical Operations at Madigan Army Medical Center.

Q: Who is your immediate supervisor?
A: (b)(6) the DCCS. She is essentially the chief medical officer for the organization and I am her deputy. I know the titles are confusing.

Q: Do you have occasion to come in contact with (b)(6) ?
A: Yes

Q: How would you characterize your routine contact with (b)(6) .
A: I meet with him several times a week. I sit in command meetings about once a week, and on an ad hoc basis passing in the hallway or talking to him when he is free.

Q: What is the command climate that (b)(6) has created at Madigan?
A: I have been assigned to Madigan for 15 years. In the 15 years I have been here I have never seen a Commander express more passion and more desire to focus the clinical efforts of this hospital on Soldiers. The Soldiers Center Medical Home is a perfect example of this. This is (b)(6) idea and his effort to get many of the medical assets that Soldiers need closer to where the Soldiers live; primary care, behavioral health, physical therapy, profile management. He has worked with sports medicine to set up a sports medicine clinic outside the hospital and close to Soldiers. He has made it very clear in all his communications that his priorities are making sure that we do the right things to take care of Soldiers.

Q: How does (b)(6) communicates his message out to the command?
A: Verbal. We have meeting where he talks about his intent. He holds town halls on a regular schedule. He meets regularly with division chiefs.

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___"

THE BOTTOM OF EACH ADDITIONAL PAGE MUST BEAR THE INITIALS OF THE PERSON MAKING THE STATEMENT, AND PAGE NUMBER MUST BE INDICATED

Ex. 10

9. STATEMENT *(Continued)*

Q: How would you compare and contrast the command climates prior to (b)(6) assuming command and how would you characterize the command climate since (b)(6) taking command.
A: In the time that I have been here we have been through periods where the command emphasis has focused on a variety of issues depending on the current environment and Commander. Now I think the focus of the last few years has been on behavioral health and assisting Commanders in the field with sustaining the force. When (b)(6) assumed command it was very clear to me that he was going to focus of caring for Soldiers. The intensity and passion that underlined that focus I have never seen expressed by any Commander in the time that I have been assigned to Madigan.

Q: How would you characterize that Madigan has performed under (b)(6) command.
A: We are a less sleepy organization than we have been in to past. I think (b)(6) is a driver and I do not mean that in a negative way. His personality style is very action oriented. He has said let's not stand around and admire the problem; let's not get caught in paralysis by analysis. He is very action oriented. He wants to see things move forward. I respect that and I think that is one of the things this organization has needed because there is a tendency to plod along. (b)(6) is very good about keeping us on target and moving forward.

Q: Are you aware of the evaluation process that FPS uses when evaluating a diagnosis of PTSD?
A: Only generally. They do administer certain psychometric tests. I don't know the details of the test or if there are other things they do. I think they also interview the Soldiers and they review all the records. They try to gather all the information and determine whether all the information that is being subjectively reported is accurate.

Q: Are you aware of the issues that have been [there was nothing written after this]
A: Yes some of the issue but not intimately involved.

Q: Are you aware of (b)(6) ever issuing guidance to FPS to use financial costs to the government when rendering a diagnosis of PTSD?
A: No. I am not aware of (b)(6) ever using his position to direct a particular outcome or to use anything other than accepted medical tests and judgment to make those determinations and I am quick to opine that the allegation that he would do so is preposterous. I have never heard of anyone suggest they had heard of him doing anything like that.

Q: Are you aware of (b)(6) direct any medical department use anything other than appropriate medical standards in making diagnosis?
A: No. I have never seen him do that; I have never heard of him doing that; and I think it is an absurd notion. It's a laughable allegation.

----------NOTHING FOLLOWS----------

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

Person Making Statement)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 30th day of March, 2012 at Joint Base Lewis McChord, Washington

(b)(6)

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

ORGANIZATION OR ADDRESS

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.

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b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/05 3. TIME 1000 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC, JBLM

9. I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: State your name and duty position.
A1: (b)(6) I am the Madigan CSM.

Q2: Describe the command climate that (b)(6) has created here at Madigan.
A2: This is the third Army Medical Center I have worked so I am familiar with a lot of different Commanders and (b)(6) is the best commander I have ever had even outside of Army hospital in the 27 years I have been in the Army. He was very clear about issues within the hospital and he communicated with everyone at town halls or meetings with senior leaders and he laid out what our issues are; what are our fiscal problems, 30 million dollars in the hole and what we had to do to get out of that hole. He was also very clear on what our main mission is as far as taking care of our patients. I thought he did an excellent job of laying all that out. He also made it clear that if we are in a leadership position he expects us to be leaders and that we are going to be held accountable and responsible for the areas that we are in charge of. He laid out the plan and it's very clear to me. All his communications are clear and what he expected. All the things like the Soldier Centered Medical Home working with the FORSCOM folks on the installation to make sure that Soldiers don't have to come to the hospital to get their medical care. That's the best initiative I have ever seen as far as taking care of Soldiers. It's going great.

Q3: How has the staff and hospital performed under (b)(6) command.
A3: (b)(6) empowered NCOs to do their job and they have been doing a great job. I would say there were some folks who didn't want to change and he took action on that as well. He helped them see what he was trying to do. So I think he is taking things the right direction. If you look at our business metrics the way they were before he got here and after they are on a steady increase. I think he was taking things the right way.

Q4: Have you been involved with the issues of some Soldiers diagnosis of PTSD being downgraded as they go through the MEB/PEB process?

9. STATEMENT *(Continued)*

A4: No really. I am aware of it from staff meetings and I am familiar with the IDES process and making that a smoother process, but other than that I really don't know anything.

Q5: Have you ever seen (b)(6) issue any guidance or directives telling them how to do business?
A5: He has never given them directions on how to make diagnosis. They are the providers and he expects them to use their skills to diagnose and properly treat the patient. Any direction he has given has been business or leadership related. He was doing a great job of the leadership be leaders. A lot of medical folks have not have the development to become good leaders so he is helping them do that. He has never told them how to do their job as a physician.

Q6: Have you ever seen or heard (b)(6) issue guidance to consider the financial costs to the government of certain diagnosis?
A6: Absolutely not. It's not within his character to do such a thing. His character is to take care of the Soldier and make sure they have everything they deserve. He would lean more to the Soldier's benefit. He has no concern as to the benefits they would be entitled to for a certain diagnosis or how much it would cost. He wants them to get accurate diagnosis and treatment.

Q7: How do you assess the moral of the hospital with the temporary re-assignment of (b)(6) ?
A7: Everyone has continued to their job but I've had a lot of people come up to me asking how they may be able to support him, they are disappointed that he was relieved of command. I haven't had a single person come up to me and say they were happy that he was gone. Everyone misses him, everyone I've talk to wants him back.

Q8: Relative to command climate, (b)(6) influence of diagnosis one way or another, would you like to add anything else?
A8: He is the best commander I have had in 27 years, especially in this environment. We works until 10 at night, midnight sometimes, very dedicated, for the right reasons. He was taking initiatives that I have never seen another doctor or commander take to help Soldiers inside and outside the hospital.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/05

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

WITNESSES

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 2 day of March, 2012 at Joint Base Lewis McChord, Washington

(b)(6)

(Authority to Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT (b)(6)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).
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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/05 3. TIME 1015 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS Madigan Army Medical Center, JBLM WA

9.
I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: State your name and position.
A: (b)(6) I am the commander of the Warrior Training Battalion. I took command on 25 May 2011 after (b)(6) assumed command of Madigan.

Q2: Would you describe your interaction on a routine basis with (b)(6) ?
A2: I interact with (b)(6) on a weekly basis. Sometimes daily but routinely about three times a week at meetings he has that I attend both for the larger staff and the smaller staff. I meet with him individually every other week, command to command, for hot topics and whatever I need to bring to him.

Q3: In that interaction, how you would describe the command climate that (b)(6) has been taking Madigan and as he steers this ship?
A3: (b)(6) has been very focused on increasing the morale by doing more social events, dining inn's, commanders receptions, Christmas parties and things of that nature. In the past, many of these events were departmental focused but now are more MAMC-wide focused. In addition, (b)(6) has a great team-building environment, and in some of our meetings, he would spend time talking about the importance of Leadership, which I believe has brought the team closer. In addition he is very fair and very Soldier focused. His wife (b)(6) coupled with the Family Readiness Group has also been a big help with keeping our families involved.

Q4: How would you describe the command climate around here, positive or negative?
A4: I would say positive and rising. However, in the last few weeks, everyone is walking on eggshells because of the investigation. I think when (b)(6) assumed command he had a big challenge given the huge financial crisis Madigan and frankly ALL Medical Treatment Facilities are shouldering. I think that this is one area that he has steered us in the right direction by critically analyzing our hiring procedures and becoming more efficient in our administrative processes.

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9. STATEMENT *(Continued)*

Q5: As one of his subordinate commanders what direction or guidance has he give you generally with the WTB?
A5: What I love about (b)(6) is that he trusts and empowers me as a commander, and he does not micromanage. He knows that we have a big mission and he also knows the troop commander has a big mission. He also knows that all of his chiefs of departments have big missions, so for him to nose dive into my battalion will just take his eyes off the bigger picture. He offered great guidance from the beginning. He laid it out from the beginning saying," Number one, do not compromise safety, no matter if you're on the difficult side of a decision, error on the side of safety and of the Soldier." Second, he mentored me to take great care of my staff.

Q6: Have you had an occasion to discuss or interact with (b)(6) on the issues that Soldiers in the WTB were having with FPS downgrading diagnosis of PTSD?
A6: Never have I discussed the medical side of this issue with (b)(6) For the most part all I have interfaced with (b)(6) is the logistics of getting the Soldiers to Walter Reed for reassessment and notifying Soldiers.

Q7: Are you aware of (b)(6) ever issuing any guidance to FPS or to any provider to use financial costs to the government as criteria in making diagnosis of PTSD?
A7: No absolutely not. My experience is quite the contrary. Some other administrative experiences I have had with (b)(6) he has always erred on the side of the Soldier. Never have I heard him say anything about issuing guidance in that realm.

Q8: Are you aware of allegations of FPS using financial costs to the government diagnosis of PTSD?
A8: Yes. My opinion is that those allegations are absolutely unfounded. I would say that every single physician's goal is to diagnosis based on clinical criteria and leave the dollars and sense to the other side of the fence.

Q9: Do you have anything further to add?
A9: This has been a real big shock to the system because our behavioral health team has been applauded a number of times as being the gold standard for the Army medical department. With (b)(6) leading our unit he has empowered and entrusted the 100s of sections in the hospital to do their job and do it to the best of their abilities. I think overall from my perspective and hearing from a lot of Soldiers we are really questioning the motive of why we are even talking about this. We know its sensitive and we are dealing with the lives of Soldiers but we don't understand why we are even talking about this stuff.

----------NOTHING FOLLOWS----------

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

ng Statement)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 12 day of MARCH, 2012 at Joint Base Lewis-McChord, Washington

(b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).
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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/05 3. TIME 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS Madigan Army Medical Center

9.
I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: Please state your name and position.
A: (b)(6) I am the Executive Officer of the Madigan Army Medical Center.

Q: What do those duties entail as the Executive Officer?
A: congressionals, basically putting out fires all day long and protecting the command suite.

Q: When you say "Protect the command suite" what do you mean?
A: From a lot of the complaints that come up, I handle a lot of them before they get to the deputies. I try and handle things at the lowest level possible.

Q: Since you have been the Executive Officer can you describe your routine interaction with (b)(6) ?
A: Every day I go into his office and update him on his calendar, and he gives me guidance on things he wants to do or things he doesn't want to do with a lot of his external engagements. I am the liaison for the PAO meetings, I run the SEC, I run a lot of the meetings he goes to and make sure all of the slides are ready for him.

Q: How would you describe the command climate that (b)(6) has created or is attempting to create here at the hospital and the direction he is trying to take the hospital with that command climate?
A: I think the climate he has instilled in the hospital is ownership in each individual's actions. I think he has made improvements over the time I have been here with several different aspects, with access to care, with saving money and making money for the hospital, I think he is firm but fair across the board for all of his endeavors.

Q: How would describe how the hospital has performed under (b)(6) command?
A: There are a lot of statistics the show things have improved over time, I think there is grumbling in the back because he is a little firm on some aspects but I think it has become better over the time I have been here.

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9. STATEMENT *(Continued)*

Q: In his interaction with the department chiefs and deputies, does he get involved down in the weeds on how they make diagnosis or how they will do their job with what criteria they will use?
A: No. I don't think he goes quite that far. He just says, "Everybody do your job, to the best you can". I don't think he directs anyone down to that level. I think he just makes sure it's what the patients need and do what the providers and doctors are there to do.

Q: How would you describe his attitude towards Soldier care?
A: I would say that is probably his top priority is being a Soldier doctor versus a doctor soldier. I think that he cares about the Soldier more than most. He has been deployed and has done the Army thing. I totally think he cares a lot about Soldier care, especially with Soldiers Centered Medical Home and some of the initiatives he has out there right now.

Q: In your position doing congressional, are you aware of the allegations relative to the behavioral health department and their review of Soldiers records in the MEB process in particular the down grading the previous diagnosis of PTSD?
A: Yes. I am in the mix just because I get the answers that come back from the departments. We put them together and send them forward to the Senator's office. As for the actual diagnosis part, I don't think I am really in the mix for that.

Q: Have you an occasion to be in any meetings with (b)(6) where it was to discussing these types of issues and what his guidance, if any, he had for the Behavioral Health section?
A: I have been in many meetings with him but I'm not sure they were really with the forsenic psychology department or the psychology department. I think it was more with the Ombudsman and the congressional staffers and not so much with the actual department.

Q: What has been his general direction with dealing with this issue?
A: He backs up the decision of the department, not influential on any decision but he wants the diagnosis that they put together to be correct, to do what they are supposed to do, to give a fair diagnosis.

Q: Are you aware of any direction that (b)(6) ever gave to FPS or behavioral health in particular to use future financial cost to the government when giving the diagnosis of PTSD?
A: No.

Q: Are you aware of anyone in the command or staff taking that tact in trying to give diagnosis of PTSD?
A: No.

Q: Relative to command climate and influencing diagnosis, is there anything further you would like to add?
A: My general impression is that there is not any influence by the command on the FPS in making decisions on diagnosis. I don't feel any of the deputies or anyone giving that guidance to the team down there to make a specified diagnosis at all.

----------NOTHING FOLLOWS----------

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

WITNESSES

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 16 day of MARCH, 2012 at (b)(6)

(Authority to Administer Oaths)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).
PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.
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b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.
DISCLOSURE: If you are a military member or a federal employee being ordered to provide a statement to assist an official investigation, providing the information is mandatory. Failure to provide information could result in disciplinary action or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations.
If you are not a military member or a federal employee ordered to provide information, or if you reasonably believe that your information will incriminate you (that is, that you are reasonably likely to admit to criminal misconduct), disclosure is voluntary, and there will be no adverse effect on you for not furnishing the information other than that certain information might not otherwise be available to the commander for his or her decision in this matter.

1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/05 3. TIME 1120 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS WTB, JBLM

9. I (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: What is your duty position?
A1: I am the Chief of the Madigan Behavioral Health Department.

Q2: What are the criteria that the Forensic Psychiatry Section (FPS) uses when evaluating Soldier's medical condition and rendering an opinion on diagnosis of PTSD?
A2: The diagnosis itself is based on the diagnostic and statistical manual (DSM). It's pretty clear cut. Anybody can Goggle PTSD and see what the criteria are. My experience with my colleagues in FPS who have done this is that they are looking to meet the defined criteria. They can use whatever tools are available to them to determine a diagnosis. A lot of it is dependent on personal history. Insofar as they can they want to corroborate that personal history. There is another skill set that is the purview of psychology where they can do pen and paper testing of somebody and results of that testing can help improve diagnostic clarity. It can help discern if somebody is over or under endorsing certain symptoms. So the process involves understanding the criteria in the DSM and looking for that based on conducting patient interviews, reviewing all available patient health records, and conducting psychometric testing if that is indicated.

Q3: Has (b)(6) ever given direction or guidance to you on what criteria FPS should be using to diagnose PTSD?
A3: His guidance has been, "Do good work." Make an honest call. Whenever someone gets one of these evaluations and the clinician comes up with a conclusion that is different than what the Soldier wants it's difficult. Sometimes some Soldiers can get so upset that they might act out in some manner, perhaps expressing threats. I don't like being a recipient of threats. My staff doesn't like being recipients of threats. The easy thing to do is just give the patient what they want. The FPS clinicians work very hard to do what is right. They conduct complete interviews and thoroughly review a Soldier's records and give their very best conclusions based on the evidence and the DMS standards. If the Soldier doesn't get something that they like they can write their Congressman and (b)(6) has visibility of those. There have been several times when (b)(6)

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Gx. 14

9. STATEMENT *(Continued)*

has called us in to discuss a case to check and see if what we are doing is fair. His guidance has always been, "I want you to be honest, I want you do good work." I have never heard any guidance from him other than this.

Q4: Has (b)(6) ever given you or FPS any guidance to consider financial cost to the government when rending diagnosis of PTSD?
A4: No. It's folly that this allegation is even being investigated. Who would advice that? (b)(6) would never issue such guidance. It's incredible that this allegation has a life when there is no basis for it.

Q5: Are you aware of (b)(6) ever giving any inappropriate guidance in rending their diagnosis of PTSD?
A5: No. What I can say is that there was a point that (b)(6) had reached a decision point. Does he do what is political expedient or does he do what he thinks is ethically right, because the two seemed to be at odds with each other. He chose to do what was ethically right.

Q6: Can you discuss the command climate that (b)(6) has tried to set in instill in the hospital relative to Soldier care?
A6: He is very much a Soldier advocate. There have been four hospital Commanders since I have been here and we are more focused on the Soldier now than I have seen under any other Commander. I think he is very Soldier focused. As far as command climate he is the type of commander who is very direct, even at the risk of being off-putting. When he arrived he held a commanders call and he was very firm on the fact that we needed to be more fiscally aware, responsible for how we are leading the staff, and accountable for our time. When he took command Madigan had an operating deficit of 25 million dollars. It got so bad that Western Region took away Madigan's hiring authority because of budget concerns. So he had a very emphatic command message that he put out. I thought what he did and his command climate were very appropriate.

Q7: How has Madigan performed under (b)(6) ?
A7: Well I can tell you about my department. Before (b)(6) arrived behavioral health was very stove piped with numerous separate sections, which was not conducive to optimal patient care. When (b)(6) arrived he recognized this and directed that we integrate. Now we are integrated into a single Behavioral Health Department and that has been a huge and positive movement.

Q8: During this re-organization of behavioral health related sections into one integrated department, did (b)(6) (b)(6) ever give any guidance to use inappropriate criteria in rendering diagnosis of PTSD?
A8: None whatsoever. The mission that FPS is doing under (b)(6) watch is the same exact mission they were doing under LTC Horoho or (b)(6) . They are doing the very same job. (b)(6) did not change a thing.

Q9: Do you have anything further to add?
Q10: I do. I trained at Tripler Hospital in Hawaii and at the time the VA had no inpatient capability at Hawaii, so the veterans came to Tripler where we took care of them. At that time one of the ways a veteran could get 100% disability was to be hospitalized 21 days. I can remember this one vet who was with us for 7 days and was ready to be discharged and then he started saying all the right things that forced our hand to keep him at the hospital longer. So some days later the same thing happened. We hit the 21 day mark and he was ready to be discharge and there was no problem, no pushback. I would submit that for us to know that 21 days was the criteria to get 100% disability was useful to understand what was motivating the veteran's behavior. A part of our job is to understand what motivates behavior. When you have a Soldier who is engaging in misconduct, we want to advise the Commander what we think is driving the Soldier's misconduct so Commanders can make

9. STATEMENT *(Continued)*

informed decisions. There are multiple things that drive behavior. One of those things is money. One of those things is secondary gain. When (b)(6) gave the September presentation to our WTB colleagues, for him to talk about being mindful of how finances can factor into the clinical picture that we are seeing is an appropriate message for that audience. If you take his statement out of context and spin it in a certain way, it can be made to look completely wrong. It can be made to look like we are trying to save the government money by deliberately denying soldiers their warranted benefits, and that is completely wrong. FPS does not make a decision on somebody being fit or unfit; the PEB decides that. We make a decision on whether a Soldier meets retention standards of AR 45-01. That's the extent of what FPS does. We do not do the calculation for disability. We do not rate somebody's disability. We need to keep in mind what is driving behavior. How do we make sense of the clinical picture in front of us? In order to do that we have to take everything into account, including how financial interest or secondary gain may or may not be playing a role in motivating behavior.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/05

9. STATEMENT *(Continued)*

I (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 3. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Signature of Person Making Statement)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths this 14 day of March 2012 at

(b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/05 3. TIME 1600 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC, JBLM

9.

I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: What is your duty position?
A1: I am the Deputy Commander for Nursing at Madigan Army Medical Center.

Q2: Describe your routine interaction with the Hospital Commander (b)(6)
A2: I meet with (b)(6) on a daily basis in our morning huddles and in the hallways.

Q3: Where you here before (b)(6) took command?
A3: Yes. I have been here since October 2010. I served first under the command of (b)(6) and now under the command of (b)(6)

Q4: Describe the command climate that (b)(6) has implemented at Madigan since taking command.
A4: (b)(6) came with some ideas to make Madigan more fiscally responsible and to make sure all providers were maximizing their appointments they needed to serve patients, making sure we were improving access to care standards, and recapture some workload that we had not had before. Before (b)(6) arrived we had allowed the retiree population to go out to the outside network to get their healthcare and he was taking the initiative to bring them back into Madigan.

Q5: Describe (b)(6) emphasis on care for Soldiers.
A5: He has had an interest in providing healthcare to Soldiers similar to what we provide our other beneficially. He has started the Soldiers Centered Medical Home to make Soldiers health care delivered in a place more conducive to providing comprehensive healthcare rather than just a medical aid room in a closet at the end of the hall.

Q6: How would you describe the performance of Madigan since (b)(6) assumed command?
A6: Madigan has improved under (b)(6) We have improved the number of patients we see, we have increased our enrollment, we are still doing pretty well with patient satisfaction.

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EX 15

9. STATEMENT *(Continued)*

Q7: How would you describe the command climate that (b)(6) fosters with his team?
A7: I think he fosters a good command climate. We are able to speak our minds and give him the advice he needs. He includes us in decision making. He has fresh eyes. He has never served at Madigan before so he brings a fresh perspective.

Q8: Are you aware (b)(6) ever giving guidance to any section in the hospital telling them the criteria they will use to make diagnosis?
A8: No. That's not something he does. He doesn't tell me how to practice nursing.

Q9: Have you ever seen him to give guidance to use financial costs to the government as a criteria in making diagnosis?
A9. Absolutely not.

9. STATEMENT *(Continued)*

The statement continues on until the end. **NOTHING FOLLOWS.**

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 10 day of March 2012 at

(b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/06 3. TIME 0913 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS Troop Battalion, Madigan Army Medical Center

9.
I, (b)(6), WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: Please state your name and current position.
A1: My name is (b)(6) and I am the Commander of the Madigan Troop Battalion and also the Chief of Human Resources here at Madigan Army Medical Center.

Q2: In your duty position please describe your routine contact with (b)(6)?
A2: (b)(6) and I see each other on a daily basis, certainly we see each other every morning at 0900 business meeting and that is held Monday through Wednesday and at 0800 on Thursday for the Command and Staff Meeting where all the other division heads are invited. In addition to that I also come up and talk to him on a daily basis with issues for the command such as UCMJ, Awards, Evaluations, things of that sort.

Q3: So you have fairly regular contact with (b)(6)?
A3: Yes Sir.

Q4: How long have you been in this duty position?
A4: This Thursday will be 8 months. I have been in the position since 8 July 2011.

Q5: So you were here before or after (b)(6) took command?
A5: I was here after.

Q6: How would you describe the command climate that (b)(6) has created in Madigan while you have been here?
A6: I would say it has been very strong and positive command climate. I will also tell you that when he first took command he held several town hall meetings where he made his expectations very clear. While some of his expectations were not necessarily popular with some of our employees they were very positive. Like doing an honest day's work for an honest day's pay, ensuring we serve as a value based standards driven organization.

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Ex. 16

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/06

9. STATEMENT *(Continued)*

Institutionally that had not always been the case and he wanted to hold us to a high standard. As time went by these ideas became very popular.

Q7: How would you describe the Madigan command climate now that (b)(6) has been here for a while?
A7: Again I would say its very positive command climate. There has been a lot of pride instilled.

Q8: How does (b)(6) continue to speak to the command and communicate with the team?
A8: He first sat down and individually counseled leaders. Subsequent to that he held routine additional town halls to let the team know the directions we are going. He also started many programs to recognized outstanding work of both civilians and Soldiers. He has placed additional emphasis on timely awards and evaluations.

Q8: How would you describe the direction of the command climate (b)(6) has created?
A8: It's a very positive path. Any numbers of my subordinates have commented on the very positive direction (b)(6) is taking this organization. Instilling pride in what we do. (b)(6) is recognizing what we doing, really pushing the organization forward.

Q9: Inside your lane of the troop battalion and Human Resources how is your team performing under (b)(6) (b)(6) command?
A9: We are improving. Our Soldiers are being better trained. We have improved under (b)(6)

Q10: How would you rate (b)(6) command to date?
A10: He is one of the best commanders I have ever worked for since joining the Army in 1985.

Q11: How does (b)(6) approach care for Soldiers?
A11: He is very dedicated to providing the best care for Soldiers and all beneficiaries.

Q12: Are you aware of any direction or guidance that (b)(6) has given to any department use financial costs to the government as a consideration when making diagnosis?
A12? I would not be in a position to hear any guidance to that, but, I will say that would be entirely uncharacteristic of any interaction I have had with (b)(6) reference his philosophy of patient care. That also flies in the face of facts because if such guidance was issued people are not following it as we have diagnosed over 1500 cases of PTSD in the last two years. It doesn't make sense from a leadership or clinical perspective.

Q13: Do you have anything further to add?
A13: Yes. (b)(6) is one of the best commanders I have ever worked for. The very concept that (b)(6) (b)(6) would try to influence a diagnosis for any reason is ludicrous. Has he been a good steward of taxpayers' dollars and directed the rest of us to do the same? Absolutely and he has done so under very public forums. He expects people to do their job and take responsibility for their actions. Bottom line, if I thought for a minute that if any diagnosis here at Madigan was being influenced by money I would not be getting my medical treatment here and I would not allow my family to get their medical treatment here. I am a field grade officer and I can easily pay for civilian medical treatment but I choose to get my families medical care here at Madigan.

----------NOTHING FOLLOWS----------

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 2. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 16th day of March, 2012 at

(b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

SWORN STATEMENT

PRIVACY ACT STATEMENT

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/12 3. TIME 1715 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS JBLM GARRISON

9. I (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: What is your duty position?
A1: I am the Joint Base Commander of Joint Base Lewis McChord.

Q2: What is your opinion of how (b)(6) cares for Soldiers here at JBLM?
A2: I have had direct observation of his interaction with Soldiers and his interaction with healthcare providers. Some of the initiative started under his command and how we better provide care to our Soldiers. Bringing care directly to the unit level like we are doing with the Soldier Centered Medical Home for 17th Fires and 555 Engineer Brigade or assisting with new unit stand-up like we are doing with 16th CAB, and his establishment of a department of sports medicine in Keeler Gym, and also he has championed an effort for new Barracks for MAMC Soldiers. He is very passionate about ensuring that we have the right providers at the unit level and making it a more efficient and effective process to get care to Soldiers. He has followed a similar approach with getting care to families and retirees in manning JBLM's two satellite clinics and how he has worked provider care and quality care at Madigan.

Q3: Can you compare and contrast what you saw of command climate and command focus on caring for Soldiers and families from previous Madigan Commanders and (b)(6) ?
A3: I would highlight an improvement in Soldier care and family care. (b)(6) came with a deployment background and operational medicine experience. He came into Madigan and looked at how he could make it more effective and efficient for the Soldiers and their families. We have seen improvements in unit level care and seen improvement in what we offer at the hospital and in the outlying clinics. I credit that back to (b)(6) operational experience and his time serving at different locations where he has gone after best practices to make his clinics and his providers more customer focused on what Soldiers and family members need in medical care.

Q4: Have you received any feedback from the JBLM community relative to how (b)(6) has done while in command?

9. STATEMENT *(Continued)*

A4: I have done several town halls that have been focused on both the civilian workforce and the customer base on delivering services at JBLM. In the last year, while (b)(6) has been in command of the hospital, I get positive comments on how the hospital has changed for the better. In reference to Madigan's customer service approach, its responsiveness, and its problem solving approach when something was identified as not going the way it should. (b)(6) and his deputy commanders would very quickly go into a problem solving approach to figure out how to make it better for the customers.

Q5: Can you describe any interaction you have had with (b)(6) relative to providing services to the Soldiers of the WTB?
A5: There have been several initiatives that have come out under (b)(6) command and they have been focused on making the WTB more effective on delivering services to Soldiers. One of his initiatives was focused on identifying Soldiers who needed to be enrolled into the WTB very early on upon their return to JBLM. He embraced and enforced the WTB board process on what conditions are accepted into the WTB, he condensed the timeline for that process, and he greatly improved the assessment process we were doing for both the active duty and reserve component Soldiers. We also looked at what was the right piece of support that I need to balance with his clinicians in reference to the Solder and Family Assistance Center. Both of those initiatives have made the SRP process for returning Soldiers more effective and how we take care of the wounded Soldiers that are in the WTB. Also, he funded DFAC upgrades in excess of $1M so that WTB Soldiers could dine in the MAMC DFAC.

Q6: What interest have you seen (b)(6) take with Soldiers processing through the MEB / PEB process?
A6: I have seen (b)(6) work on reducing the amount of time Soldiers are stuck in the MEB / PEB process. He has worked to bring in additional civilians to work in the IDES process and seeing how he has gone after resources to make sure that unit Commanders are able to get their Soldiers processed through the MEB / PEB rather than lingering on and waiting for medical support. He worked on finding and dedicating space for VA and other personnel in order to provide better customer service.

Q7: Are you aware of (b)(6) ever issuing guidance to any providers at the hospital to use financial cost to the government as criteria in diagnosing PTSD?
A7: No, I have never seen nor heard him do anything improper about identifying a financial string attached to a particular medical diagnosis. I am aware of (b)(6) enforcing a standard for the medical providers to do what is right. I am privy to several hospital staff meetings that I was invited into based on the installation services I provide in which he talked to his behavioral health leadership that we must do what is right for the Service members and Family members no matter what! He said, we must look at every document that is provided and that we ask every question so we ensure that our diagnosis is the most accurate for that Service member.

Q8: What is your assessment of (b)(6) as a Commander at Madigan?
A8: He is a superior Commander; respected by all his peers, subordinates, and superiors alike. (b)(6) has re-instilled military standards to the hospital in reference to customer service, reporting standards, and good order and discipline. He has enforced standards to do the harder right rather than the easier wrong. The greatest compliment I can pay to a peer is that I would work for him and I would work for (b)(6) in a heartbeat.

Q9: Do you have anything to add?
A9: Yes. In the two and half years of running this installation and providing services to our large customer base I have had almost daily interaction between the previous Hospital Commander (b)(6) and the current Hospital Commander (b)(6) I would tell you that (b)(6) has done nothing but make that hospital

9. STATEMENT *(Continued)*

better for all of our Soldiers, family members and retirees and the best thing we could do is ensure we get continued service as the Madigan Commander out of (b)(6)

(b)(6) (b)(6)

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/12

9. STATEMENT *(Continued)*

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(b)(6)

WITNESSES

(b)(6)

ORGANIZATION OR ADDRESS

JOINT BASE GARRISON
JBLM, WA 98433

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 20 day of MARCH, 2012 at

(b)(6)

(Authority to Administer Oaths)

INITIALS OF PERSON MAKING STATEMENT (b)(6)

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).
PRINCIPAL PURPOSE: To collect facts necessary to assess the behavioral health diagnostic process in Medical Evaluation Boards conducted at the Madigan Healthcare System and to identify and address factors affecting the appropriateness and fairness of that process.
ROUTINE USES: Any information you provide may be disclosed to members of the Department of Defense (DoD) who have a need for the information in the performance of their official duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:
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b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.
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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/06 3. TIME 1800 4. FILE NUMBER _____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS 16th COMBAT AVIATION BRIGADE (CAB), JBLM

9.
I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: What is your duty position?
A1: Commander of the 16th Combat Aviation Brigade.

Q2: What is your evaluation of (b)(6) and his care for Soldiers?
A2: Any new Commander who comes in does their normal 30-60-90 day assessments. One of the things I had to assess was my aviation medical clinic or lack thereof. It's normal at most installations where you have a combat aviation brigade to have some type of aviation medical clinic. There hadn't been a CAB here for a long time and the aviation medical clinic here at JBLM was Winder clinic which also services several other brigades. I also happen to be within my flight physical window so I had the opportunity to go over and do my commander's assessment and also do a flight physical. What I immediately realized was that with 2500 Soldiers in the CAB and a requirement for 1000 flight physicals a year, Winder Clinic was not going to be able to handle the 16 CABs medical needs. I immediately started asking questions as to we why we didn't have a dedicated aviation clinic and what can we do about getting an aviation medicine clinic. I learned that there were no plans to create an aviation medical clinic beyond providing the 16 CAB daily sick-call at Old Nisqually clinic, which are relocatable trailers and belong to the Western Region Medical Command. I immediately talked to (b)(6) about my concerns of 16th CAB needing an aviation medicine clinic. Because it involved potentially Western Region likely having to give up office space and Madigan having to pay money for equipment to source the aviation medical clinic, my expectation was I would get resistance. When I approached (b)(6) about this he immediately made time for me and brought in all the interested parties and was fully supportive of creating an aviation medical clinic. (b)(6) was fully supportive of the clinic and advocated for 16th CAB. In January I sensed the momentum for the clinic slowing down and it took just one call to (b)(6) (b)(6) and the momentum picked right back up. Now we are ready to open the clinic on April 1st and it will serve not only 16 CAB but all of the aviation units at JBLM. One thing that (b)(6) insisted on with regards to creating the clinic was that we provide quality care. (b)(6) is truly committed to providing the best care possible to all soldiers here at JBLM. He stressed that he wanted the clinic done right.

ADDITIONAL PAGES MUST CONTAIN THE HEADING "STATEMENT OF ___ TAKEN AT ___ DATED ___"

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EX. 18

9. STATEMENT *(Continued)*

Q3: How would you describe (b)(6) effectiveness as the Hospital Commander in providing medical services to your Soldiers and his care for Soldiers?
A3: All I have ever heard anyone say since (b)(6) took command of Madigan is that improving health care services at Madigan has been his number one priority. On a personal level (b)(6)
(b)(6)
(b)(6) I thought it was pretty significant that he would take that much personal interest in us and everything I have heard is that he does that with everyone.

Q4: How would you characterize (b)(6) caring for the aviation community and your Soldiers?
A4: I think a common gripe of Soldiers is never being able to get a medial appointment or some type of medical issue at most installations, but I can honestly say that I can't think of one instance where I have heard Soldiers complaining about Madigan. That's not because Soldiers are afraid to complain – they will if warranted. Everything I have heard from my Soldiers is complimentary of Madigan and the medical care they receive.

Q5: Is there anything else you want to add?
A5: I have a CPT acting as my brigade surgeon and I am authorized a major. I had heard great things about a previous flight surgeon who was an ER resident at Madigan who was also known and recommended by a couple of my battalion commanders. I really thought that a ER trained flight surgeon was a great fit for the brigade to get our brigade medical program going. I discussed this with (b)(6) and he gave me his full support. I can't say enough good things about (b)(6) He is intelligent, articulate, cares deeply about soldiers and is a great role model for any officer.

----------NOTHING FOLLOWS----------

9. STATEMENT *(Continued)*

I, (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE ___. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Signature of Person Making Statement)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 20 day of MARCH, 2012 at Joint Base Lewis McChord, Washington

(b)(6)

(Authority to Administer Oaths)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/03/06 3. TIME 1630 4. FILE NUMBER _____

5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)

8. ORGANIZATION OR ADDRESS 17TH FIRES BRIGADE, JBLM

9.

I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q1: What is your duty position?

A1: Commander of the 17th Fires Brigade.

Q2: Have you had an opportunity to work with the Commander of Madigan (b)(6) ?

A2: Absolutely. A number of months ago (b)(6) approached us and was interested in bringing better healthcare to the Brigade's area. So we partnered with 555 Engineer Brigade and we established, with (b)(6) help, a Soldier Centered Medical Home. (b)(6) concept was to pool together the two brigade's resources and then bring MEDCOM assets into the Soldier Medical Care Home and have Soldiers treated right in the Brigade's footprint instead of going to Madigan. The lost travel time, the bureaucracy of finding the appointment place, we could have those appointments right here in the Brigade area and it's really significant. First with physical therapy. (b)(6) brought in about $100,000 plus dollars of equipment and a physical therapist at least three days a week. Then he provided a behavioral health specialist and a technician. (b)(6) concern was to provide better behavioral healthcare treatment in the Brigade footprint and we are seeing that already. When our Physicians Assistants have a behavioral health question or our Soldiers who may be experience what they perceive as symptoms of PTSD they can walk straight over to our behavioral health specialist and get answers or a consult right on the spot. It has been very, very, effective and it would not have happened if it was not for (b)(6)

Q3: How would you characterize (b)(6) care and devotion to Soldiers?

A3: In my experience he is very concerned about giving Soldiers great care right down into the brigade footprint and he put that into action with a ton of resources. It's the most amazing thing I have seen over the last eight or ten years as far as MEDCOM folks being involved to increase the quality of care for the Soldier and I think it's phenomenal.

Q4: How has (b)(6) been supporting the Soldier?

9. STATEMENT *(Continued)*

A4: My instinct is that if (b)(6) had not been there we would not have behavioral healthcare in our brigade footprint. We would not have that resource for our Soldiers today had it not been for (b)(6) I am greatly appreciative of (b)(6)

Q5: Do you have anything further to add?
A5: I was very impressed with the way (b)(6) worked the problem set collectively between FORSCOM, IMCOM and MEDCOM all with the goal of providing better care in the brigade footprint. Over a relatively short number of months we put his idea into action and our Soldiers are getting better healthcare. The three or four of us colonels routinely would get together with (b)(6) and work things out. Clearly (b)(6) MEDCOM folks were energized by (b)(6) vision. It was unbelievable. They had the clear vision from (b)(6) and they executed. It was simply amazing and we are going to benefit from this for years to come.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/03/06

9. STATEMENT *(Continued)*

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(b)(6)

(Signature of Person Making Statement)

WITNESSES

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 19 day of March, 2012 at Joint Base Lewis-McChord, Washington

(b)(6)

INITIALS OF PERSON MAKING STATEMENT (b)(6)

PAGE 3 OF 3 PAGES

SWORN STATEMENT

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, United States Code, Section 3013 (10 USC § 3013).
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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/02/28 3. TIME 1100 4. FILE NUMBER
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS EAGLE APPLIED SCIENCE, LLC

9. I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your job?
A: I am a MEDCOM contracted ombudsman. My job is to be an impartial mediator for the medical treatment facility (MTF) community.

Q: In your job as an ombudsman have you come in contact with Madigan's forensic psychology department and their role in evaluating soldiers' diagnosis of PTSD?
A: Yes. I started working on the forensic psych complaints probably as soon as August 2010, before (b)(6) (b)(6) came on board. I have had extensive experience with complaints with the forensic psych department.

Q: How would you describe your knowledge of the criteria that the Madigan FPS section uses to consider a diagnosis of PTSD? How much of what goes on behind closed doors, in layman terms, do you feel you know?
A: I know some of the bits and pieces of the process, but I have not participated in an examination so I cannot really speak to all the nuts and bolts. I can tell you they go through psychometric testing, they will go through a record review, there will be records requested, there will be personal interviews that could range from 10 minutes to 3 hours, sometimes no personal interview, and then a construction of the report. I am also familiar with what is known as the "Gold Standard of Testing" that they put the soldiers through, and some other psychometric testing that they do to try and assist them in their diagnosis

Q: Would you characterize yourself as having an outside individual's fairly good working knowledge of what the process is that they do?
A: A very layman way of looking at it, yes. I think so.

Q: Are you aware of any FPS providers here at a Madigan considering financial costs in their determination of whether a soldier has PTSD or not?
A: Are they looking at a particular condition through a financial lens? Yes, because their mission is to determine whether a soldier has a compensable or non-compensable condition. Does that lend a particular

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Ex. 20

9. STATEMENT *(Continued)*

basis? Yes. I have not had a dialog with anybody other than the chief of forensics that spoke about money because I don't talk to FPS providers. I could not tell you one way or another if that's the way they were looking at it. I can only say that the discipline itself and the purpose of it is serving in the MEB process and is to identify a compensable or non-compensable condition.

Q: Are you aware of any FPS doctors here at Madigan were using financial cost to the government in their diagnosis of PTSD?
A: No.

Q: Do you believe or are you suspicious that anyone in the FPS department may have inappropriately used cost to the government to render a decision of PTSD?
A: I have a suspicion that costs could be a consideration. I base this suspicion on the concerns raised by the Soldiers, facts, trends, or patterns that were identified over the course of a year.

Q: What leads you to have that belief?
A: Again, it is not a belief, it is an assessment based on the facts, trends, and patterns brought to me by concerned Soldiers. However, the 1 September 2011 presentation by (b)(6) for one thing, and then we had a couple of other meetings where cost was mentioned. It is not just that one lecture. It's after a year of hearing soldiers saying "I've been an in-patient, I've been in combat medic for 32 months, and then seeing those adjustment disorder [diagnosis from FPS] pop up after they have been in treatment for 6 years for something that is supposed to be short term. Then turning around and watching someone say, "You do not have PTSD according to FPS so now we are going to administratively separate you for a personality disorder." So it was very hard to say it was only that [(b)(6) 1 September 2011 presentation]. I think it was a culmination of everything that I've received from the soldiers to the leadership that talked about malingers, liars, and some of the statements in the reports that are truly inappropriate and unprofessional. All of those things together I can't help but also make those correlations. True or not, directed or not, it doesn't matter. Perception is a big portion of this thing, and that perception was not hard to make once we got the lecture.

Q: So, you have the perception at the FPS was using financial cost to the government of a PTSD diagnosis in rendering their decision on if a soldier had PTSD or not?
A: I will not say it was a definitive reason for what they did. That's not what I am saying. I am saying it could have influenced their decision.

Q: Are you aware of the Madigan command directing FPS to consider financial costs to the government when rendering their diagnosis of PTSD?
A: No. For all I know the cost could have come up in a very benign discussion. It could all be chalked up to a complete deficiency in communications. The problem is we did not manage it well.

Q: Do you know if (b)(6) directed FPS providers to consider criteria beyond the standard medical accepted criteria in determining a diagnosis of PTSD?
A: No. I have no knowledge of that.

Q: Do you have any knowledge of (b)(6) actively influencing the consideration of non-medical criteria such as financial cost to the government in FPS's diagnosis of PTSD?
A: No.

9. STATEMENT *(Continued)*

Q: Do you have any knowledge of (b)(6) in any way, shape, or form influencing FPS in their diagnosis of PTSD?
A: No. He came in late in the game. They were already on the path they had chosen, whatever that is, whatever their processes were.

Q: Are you aware of any diagnosis of PTSD by FPS for soldiers that did not previously have a diagnosis of PTSD?
A: No. I only know the teeny tiny percent of the soldiers that complain. That's all I get.

Q: Are you aware of any influence (b)(6) had, any guidance or directives he gave to FPS in making diagnosis of PTSD?
A: Only his support for the department. That's it. We had three meetings, I think, with (b)(6) and at every meeting FPS was discussed. I am not a MTF commander and I do not have his perspective, but I didn't feel he had an open mind about it. I felt they did their homework, they reached their decision, and what I had to say was not necessarily received with any creditability or merit. He said he had full faith and confidence in his providers many times. I walked away from those meetings feeling nothing was going to change.

Q: Do you have any opinion on the command climate that (b)(6) fostered at Madigan and the support and care for soldiers?
A: I was aware of the meetings where he brought in the providers to the auditorium and was spitting mad, and discussing and cussing about the way we were doing business. About accountability, about appointments, and quality of work, the whole nine yards. That first meeting was rather interestingly interpreted by several people. He was very angry with the way Madigan had been run, and talked about Madigan's budget, and how terrible it was, and a lot of things.

Q: Was he trying to improve quality, or what?
A: Oh yes, absolutely.

Q: Would you characterize that is what hospital commanders are supposed to do?
A: Yes.

Q: What type of command climate was (b)(6) attempting to set?
A: That you would be accountable for every minute of your day while you are on my payroll.

Q: Final question, are you aware of any inappropriate influence or guidance that (b)(6) had or gave to the FPS providers relative to diagnosing PTSD?
A: I would hope he had nothing to do with that. I am not aware of that at all. I have no personal knowledge that (b)(6) ever did anything as far as influencing PTSD diagnosis or not.

----------NOTHING FOLLOWS----------

STATEMENT OF (b)(6) TAKEN AT Joint Base Lewis-McChord DATED 2012/02/28

9. STATEMENT *(Continued)*

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(Signature of Person Making Statement)

WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths, this 8 day of March 2012 at (b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)

SWORN STATEMENT

PRIVACY ACT STATEMENT

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1. LOCATION Joint Base Lewis-McChord 2. DATE 2012/02/28 3. TIME 0900 4. FILE NUMBER ____
5. NAME (b)(6) 6. SSN (b)(6) 7. GRADE/STATUS (b)(6)
8. ORGANIZATION OR ADDRESS MAMC, JBLM

9. I, (b)(6) WANT TO MAKE THE FOLLOWING STATEMENT UNDER OATH:

Q: What is your job, and what do you do?
A: I am a MEDCOM/OTSG Ombudsman located at the Warrior Transition Battalion/MAMC, JBLM. We address issues from Soldiers, Family members, retirees, and anyone who has an I.D. card. If they have any type of issue, concern, or complaint, whatever the case may be, that they feel they have tried to get it resolved somewhere else and they cannot get the issued resolved, they can contact the Ombudsman for assistance in resolving the issue. When the position was created 4 years ago, the focus was on the Soldiers and family members in the WTB. When I started in October 2010; and it was at that point LTG Schoomaker made the decision to expand the Ombudsman's availability to any Soldier or family member.

Q: How do you become involved in Soldiers who have had diagnosis of PTSD changed by FPS?
A: The issue has been with Soldiers who were diagnosed with PTSD at some other location and it was determined that they failed to meet retention standards and a medical board was recommended and from that point the Soldier was brought to JBLM to go through the MEB process. The conflict has been the Soldier gets here, goes through FPS testing, and then the FPS evaluation comes out different than what they were sent here for. So different that they were told they do not have PTSD in some cases. So different that the PTSD diagnosis from the original provider is changed to adjustment disorder. Once the FPS evaluation came back and said you do you not have PTSD you actually have adjustment disorder their board was stopped if there were no other conditions which fail to meet retention standards.

Q: What has been your involvement with Madigan's FPS department and Soldiers who undergo this evaluation process and have their diagnosis of PTSD changed?
A: I got involved for the first time in August 2011. A soldier who was told by FPS that he had adjustment disorder, not PTSD, was referred to me by his nurse case manager. His nurse case manager was very concerned and she said "I do not agree with this. Something is not right, I'm going to have the Soldier come and talk to you and see if there is something you can do to help." This case was the first time I had any interaction with FPS. I talked to the Soldier, he told me his whole story, and he indicated he was very confused. He stated he

9. STATEMENT *(Continued)*

was evaluated in Korea and had been treated for PTSD for about 8 years, and he is currently at a point he cannot manage it any longer. He stated he would like a care conference convened in order to understand what was going on. In the care conference the battalion surgeon read the FPS report to the soldier which totally blind-sided him as that was the first time he had heard or seen the FPS report. He was very upset and stated some information in the report were not correct, they are calling me a liar, and they are calling me a malingerer. Now I was confused; I had never seen that happen before in a care conference. I called and asked to schedule a meeting with the WTB Bn Surgeon accompanied by the soldier and his Social Worker. However when the soldier realized the WTB Bn Surgeon was the same individual who disclosed his FPS Report in the Care Conference he declined to meet with him. I then called and asked to meet with the DCCS who gave me an appointment that day. On the 25th of August 2011, my co-worker, (b)(6) who was working several cases involving similar issues with FPS, and myself met with the DCCS. We explained our issue and the DCCS thanked us and said she would look into the issues and follow up with us. The Soldier told me he was going to take this to the next level and write his congressmen about the issue. The next major issue was extreme difficulty of the Soldier obtaining his FPS records. After being told by (b)(6) that the FPS records were released, the Soldier and I attempted to collect his FPS records through normal procedures but were unsuccessful. After extreme difficulty and numerous delays the Correspondence Supervisor, (b)(6) was able to obtain the Soldier's records through what I was told was a "back-door" non standard method. I asked to speak to (b)(6) about the issues with this soldier, and another soldier who I had two outstanding issues with FPS...changing of the PTSD Diagnoses to Adjustment Disorder and a complaint from the soldier on how he was treated by staff and the provider.. I met for about 3 hours with (b)(6) and (b)(6) the Chief of Department of Psychiatry. (b)(6) apologized for what he called the catastrophe of getting the report, an email that (b)(6) sent my boss, and the effort that I and the soldier had to go through to get the Soldiers' FPS report from my department. (b)(6) assured me that was not the standard and that he would insure that never happened again. (b)(6) then explained the FPS process and the difficulties in making behavioral health diagnosis. When I asked what gives the FPS department the ability to change a Soldiers previous diagnosis of PTSD, (b)(6) stated that the Madigan FPS department was the "Gold standard" of FPS and they have been given the authority to do evaluations and if appropriate to change a Soldier's diagnosis of PTSD. I do not know who gave them this authority. I know it was not (b)(6) because this was happening before (b)(6) took command of Madigan. I stated that there is a MEB and PEB process and that I do not understand how a Soldier could come to FPS, take one 500 question test, and their life is turned upside down because a change in their previous diagnosis. How can this be? (b)(6) ended the meeting requesting the Soldiers phone number so he could apologize to the Soldier; (b)(6) stated he needed the clinical data from the soldier's inpatient treatment to review the change to adjustment disorder. I stated I could get the report. I had a second meeting with (b)(6) and the second Soldier who I was working with who had FPS issues. The provider reviewed the FPS file with the Soldier. (b)(6) stated that he changed the process of getting FPS records so that in the future Soldiers could obtain their FPS records through the normal process. I had a third meeting with (b)(6) one of his providers, a Soldier and his wife reference similar FPS issues. We identified several administrative issues that (b)(6) said he would fix and then we reviewed the soldiers FPS records. This was the extent of my interaction with FPS.

Q: How do you describe your routine interaction with FPS?
A: If a Soldier bring me an issue with FPS I try to resolve, highlight, negotiate, can we come to a different outcome, or at least get clarity between whoever has the issues. I try to bring everyone together to communicate. So it's not a day to day interaction. I had been in the position for a year before I ever saw FPS. It really depends on a specific FPS issues as to how often I meet with them.

9. STATEMENT *(Continued)*

Q: Are you aware of what the criteria FPS uses in rendering a diagnosis of PTSD?
A: My understanding is they give a test called the MMPI, and they use the test to determine if the Soldier has PTSD. They way they do it here is different than the way they do it at Walter Reed. My understanding is this is the only test to determine if a Soldier is fit for duty or not. I think I have more knowledge of the process having gone through this with the Soldiers. Prior to this I really had no clue.
Q: How you describe your knowledge of the inner-workings of FPS in rendering findings of PTSD?
A: I would not say I have an intimate and detailed knowledge. There could be other things that are done which I would not know about. I have an overall knowledge and pretty comfortable knowledge but not an intimate detail since working with the first soldier in August 2011.

Q: Are you aware of any FPS providers considering financial cost in rendering their diagnosis of PTSD?
A: Well we had a provider discuss cost at a lecture we were mandated to attend on 1 September 2011. (b)(6) (b)(6) asked the question if anyone knew what the cost to the government was of a PTSD diagnosis. He stated the cost was 1.5 million dollars. He stated we were diagnosing Soldiers with PTSD at a rapid rate and at this rate we will bankrupt the Army and the VA. I was stunned and I whispered to another person, "So that is what this is all about. This is all about money?" She looked at me and said, "Apparently so." I stated, "You have got to be kidding me, I thought we were here to provide the best care for Soldiers." As I was hearing this I realized it is all about the money. Never before had I heard anyone talk about money. He stated the money issue very competently. It was as if he was saying, "Look, this is supported by the higher up. This is the deal folks, pay attention to what you are doing, think about it every time you want to say someone has PTSD and think about the fact that it is now going to cost us 1.5 million dollars." That's what I took from it.

Q: Do you believe that the FPS providers or section at Madigan are taking in account financial cost of care in rendering in diagnosis of PTSD?
A: Yes.

Q: What do you base that on?
A: I base it on Soldiers who have come to me with issues of their PTSD diagnosis being changed, their FPS evaluations having language of them being liars and malingers, a couple of FPS providers telling Soldiers they did not believe in PTSD. So for me the light went on when (b)(6) made the statement that a soldier can earn $1.5mil dollars over an average lifetime when diagnosed with PTSD.. I started thinking back to what the Soldier's issues were and I thought, "Oh, no wonder they are changing the diagnosis. Now it makes sense." Before, I could not figure out why the diagnoses were being changed. So for me that is what I took away from (b)(6) 1 September lecture, that yes I feel that FPS was operating in some instances, and I won't say all, but there seems to be a lot of cases where the diagnosis was changed because of money. And it seems to be predominately pointed to one provider. That name came up more so than any of the other providers.

Q: What provider is that?
A: (b)(6)

Q: Are you aware of any evidence of FPS providers using financial cost in rendering their diagnosis of PTSD?
A: No, I do not have any evidence.

Q: Would be fair to say you have a gut feeling FPS was using financial cost as a factor?
A: Well, it's not only a gut feeling but it was sitting through that lecture and hearing (b)(6) say how much it cost.

9. STATEMENT *(Continued)*

Q: Is it fair to say that your belief that (b)(6) was using financial cost to the government as a consideration in determining her diagnosis of PTSD was formed in your mind by the statement of (b)(6) at the 1 September meeting?
A: Yes. And the number of Soldiers who have come forward with the same story of their diagnosis being changed due to their FPS evaluation. So in my mind, gut feeling, lecture, hearing 1.5 million dollars, do I have anything in writing say they have a matrix, no I do not have that.

Q: are you aware of any of the FPS providers have been given direction to use financial cost as a consideration in rendering a diagnosis of PTSD?
A: No.

Q: Do you know if (b)(6) directed providers to consider criteria beyond the standard medical accepted criteria in rendering a diagnosis of PTSD?
A: No.

Q: Are you aware of (b)(6) actively influencing the consideration of non-medical criteria such as long term cost to the U.S. government in FPS doing their evaluations of PTSD?
A: No, because I believe all these evaluations were done before he took command or just as he took command. I don't think he was in command when the evaluations were done. I cant say I know anything about him influencing at all.

Q: So you are not aware of any influence, guidance, or direction that (b)(6) had on the FPS providers?
A: No.

Q: Have you ever discussed any of these issues with (b)(6) ?
A: Around 25 September, he asked to meet with me. He started the conversation by stating he likes to be transparent, it makes it simpler that way. He asked me if I sent the Surgeon General information about 4 soldiers that had issues with FPS. I stated that the issue with FPS had gotten to the level because we had gone to my boss at MEDCOM stating we were concerned about the trending up of reversing PTSD diagnoses. Our goal was to determine if any other Ombudsman were having similar problems and what were best practices. (b)(6) said, "Ok. Let me tell you. OTSG kind of wants to get in everyone's back yard and want to tell people on the ground what to do, and they are there and we are over here. I am not buying this whole PTSD thing. I have spent time downrange and I know about PTSD and everybody is jumping on this PTSD bandwagon." I stated I am not a doctor and all I can do is address issues that Soldiers bring to me. He then asked me if I was getting the help I needed from his staff. To which I replied I was. He asked if the DCCS had been helpful to me. To which I replied yes. He stated, "Great. That's what I want. I want to make sure that when the Ombudsman asked to present an issue that we are able to meet with you." Then (b)(6) quickly reviewed the 4 cases in question and essentially repeated the opinions that (b)(6) had on each case. He didn't come out and say the Soldiers were liars and malingers but my perception was that he just felt that they were all in this together trying to get something out of the military. He was very nice, he was not mean, he was not rude, he was very pleasant. He stated his opinion and said these Soldiers do not have PTSD. I stated I am not a doctor but I believe the Soldiers. I have spoken with them and their wives at length, they are in counseling, the whole dynamic of the family has changed. I just don't think they are making this up. That's my opinion for what it is worth. That was my last conversation with (b)(6) on this issue.

9. STATEMENT *(Continued)*

Q: Do you believe (b)(6) gave guidance to FPS to use financial cost in determining diagnosis of PTSD?
A: No.

Q: What is your opinion of the command climate that (b)(6) fostered relative to care of the Soldier?
A: I am not aware of anything about (b)(6) command climate. Personally I think there was a negative climate before he got here.

Q: Do you have anything further to add?
A: No. I just think the way FPS was set up was done before (b)(6) got here. If you look at the number of patients that FPS saw, and I think it was prior to maybe even the summer of last year. I think they were only seeing about 50 patients a month. The whole intensive outpatient program that was closed. After that program was closed they started seeing 50 patients a week. That's huge. This is just me thinking that something happened here. What happened that we went from seeing 50 patients a month to seeing 50 patients a week? Is it because the IOP closed? Is it because there was some type of guidance from somebody about money? That, Oh! We have too many people being diagnosed with PTSD. Was that why that IOP was closed and FPS was giving the authority to now be the washing out and gate keepers of who gets the diagnosis and who doesn't? I do not know. That is just the things that have been in my mind. I am trying to figure out what is going on here. Especially when it's not the way Walter Reed does it. So we have Walter Reed, a medical center; Madigan, a medical center; two places; two coasts; two forensic psychology departments. Why is one operating totally different than the other? They both have medical boards and they both have PEBs in their region.

Q. Again, my investigation is narrowly focused on (b)(6) and any influence he has.
A. No, I don't think there was any influence from him.

----------Nothing Follows----------

9. STATEMENT *(Continued)*

The statement continues on until the end. **NOTHING FOLLOWS.**

I (b)(6) HAVE READ OR HAVE HAD READ TO ME THIS STATEMENT, WHICH BEGINS ON PAGE 1 AND ENDS ON PAGE 5. I FULLY UNDERSTAND THE CONTENTS OF THE ENTIRE STATEMENT MADE BY ME. THE STATEMENT IS TRUE. I HAVE INITIALED ALL CORRECTIONS AND I HAVE INITIALED THE BOTTOM OF EACH PAGE CONTAINING THE STATEMENT. I HAVE MADE THIS STATEMENT FREELY WITHOUT HOPE OF BENEFIT OR REWARD, WITHOUT THREAT OF PUNISHMENT, AND WITHOUT COERCION, UNLAWFUL INFLUENCE, OR UNLAWFUL INDUCEMENT.

(b)(6)

(Signature of Person Making Statement)

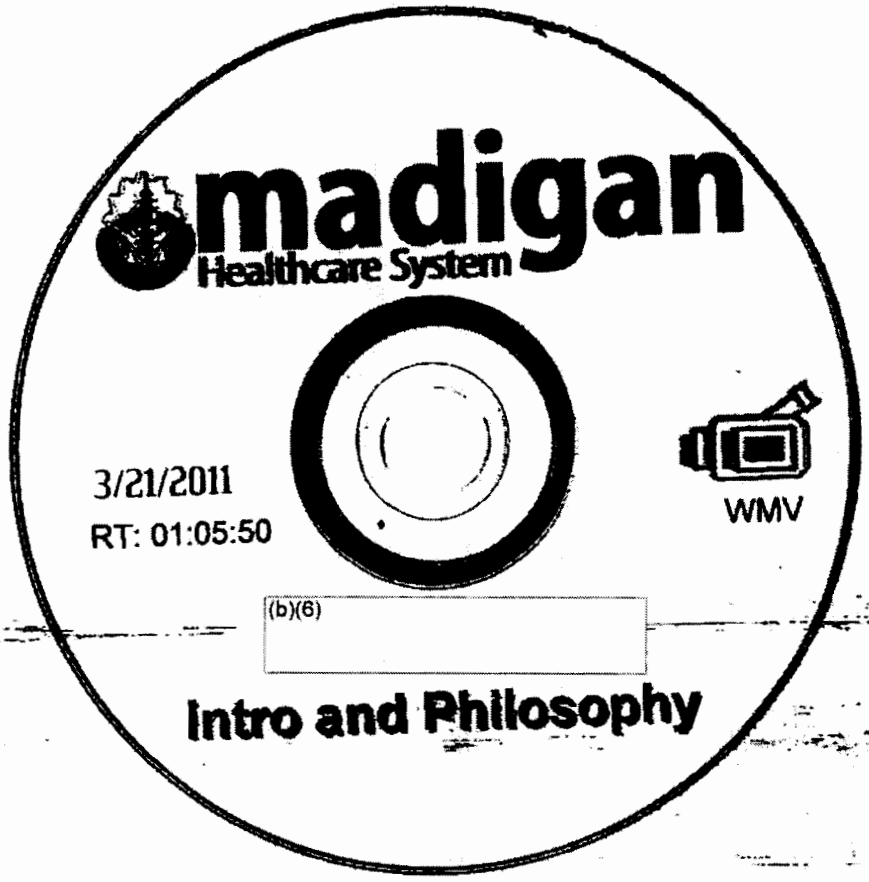
WITNESSES

Subscribed and sworn to before me, a person authorized by law to administer oaths this 7th day of March 2012 at (b)(6)

ORGANIZATION OR ADDRESS

ORGANIZATION OR ADDRESS

(Authority to Administer Oaths)


madigan
Healthcare System
3/21/2011
RT: 01:05:50
WMV
(b)(6)
Intro and Philosophy

Ex. 22


madigan
Healthcare System
2/13/2012
RT: 00:55:35
WMV
(b)(6)
Town Hall

ARMY MEDICINE

MTF Inpatient Workload	12 Months Oct10-Sep11	Baseline FY10	MEDCOM FY11 Target
[redacted]		1,870.46	1,952.60
[redacted]		1,240.39	1,413.80
[redacted]		382.61	425.60
[redacted]		446.40	422.60
[redacted]		285.42	332.60
[redacted]		638.92	704.00
[redacted]		1,033.75	1,081.30
[redacted]		1,366.93	1,948.80
[redacted]		1,161.58	1,632.20
[redacted]		3,859.33	3,984.40
[redacted]		1,086.38	1,082.40
[redacted]		18,372.18	14,960.30

Outpatient Workload	12 Months Nov10-Oct11	Baseline FY11	MEDCOM FY 12 Target
[redacted]		18,009.84	
[redacted]		59,007.87	
[redacted]		168,958.08	
[redacted]		344,780.66	
[redacted]		316,614.38	TBD
[redacted]		178,790.18	
[redacted]		210,077.81	
[redacted]		236,000.82	
[redacted]		133,893.04	
[redacted]		1,232,471.79	
[redacted]		36,971.63	
[redacted]		80,359.89	
[redacted]		3,015,935.99	0.00

Sources: M2 SADR, M2 SIDR and PPS Reconciliation files

(b)(6)

- MAMC Outpatient Workload exceeding Business Plan objectives
- MAMC Inpatient Workload has increased from FY10 baseline
- Funds earned from total increased workload were $16M for FY11
  - Negative $5.0M for FY10
- MAMC has already earned $10M in additional workload revenue for FY12
  - Projecting $24M for FY12
- Medical Efficiencies and Admin adjustments have remained positive within the Performance Based Adjustment Model
- Overall Patient Satisfaction @ 92.20%
- Madigan HS total obligations of $520M for FY11
- MAMC recognized and awarded 200K for increased workload in both inpatient and outpatient services
- Initiated Soldier Centered Medical Home
- Initiated Sports Medicine Clinic

1. The Business of Madigan under (b)(6)
    a. Under (b)(6) outpatient visits to the hospital has increased significantly. Specifically outpatient visits and their production (RVUs) have increased from an objective of 3,015,935 to 3,058,214.
    b. Madigan Inpatient workload has also significantly increased from 13,372 RWPs to 13,966.79 RWPs.
2. The increase in workload was based on (b)(6) vision and his insistence that clinic directors be accountable for their clinic hours. His decision to increase enrollment to retirees (past warriors and their families) and ensuring that Active duty personnel and families were seen at Madigan primarily, directly resulted in the increases mentioned above.
3. Under the MEDCOM's Performance Based Adjustment Model, Madigan has increased from a negative $5M adjustment, when (b)(6) assumed command, to a projected $24M positive adjustment for FY12. That represents a $29M turn around during (b)(6) tenure. This figure suggests that both Active Duty and Retiree care increased significantly and that the Commander's focus was directed toward ensuring accountability with Hospital providers and staff. Madigan was awarded a $200K award at the recent Military Health Conference for increased productivity.
4. (b)(6) initiated the Soldier Centered Medical Home
5. (b)(6) approved the Sports Medicine Clinic proposal at Keeler Gym

C. ANALYSIS OF CASES WHERE MEB WAS INITIATED AS NON-BH DIAGNOSIS (Referred for physical condition):

In the course of the MEB process (C&P exam or MEB Physical Exam for legacy cases) these Soldiers claimed a Behavioral Health condition without previous medical documentation in their health record:

Of the MEBs Initiated for Non-BH Diagnoses:	2611
Number of BH Dx Claimed:	800 (31%)
PTSD Claimed:	310 (39%)
Other BH Dx Claimed:	490 (61%)

1) FOR PTSD CLAIMED:

Number of PTSD Claimed:	310
Number Referred to FP:	194 (63%)
Number given BH Dx:	155 (80%)
Number given PTSD Dx:	43 (22%)
Number of PTSD Dx referred to FP resulting in non-PTSD Dx:	**151 (78%)**

2) FOR OTHER BH DX (NOT PTSD) CLAIMED:

Number Other BH Claimed:	490
Number Referred to FP:	285 (58%)
FP gives BH Dx:	233 (82%)
PTSD by FP:	31 (11%)

3) ANALYSIS:

Of the 194 cases referred to FP where PTSD was claimed :
- ***43 were diagnosed clinically with PTSD. (22%)***
- ***151 were diagnosed clinically without PTSD. (78%)***
- ***112 where diagnosed clinically with other BH Dx. (58%)***
- ***39 resulted in no BH diagnosis. (20%)***

D. TOTAL CASES TERMINATED:

Total Number of Terminated MEB Cases:	682
Initiated for BH Diagnoses:	117 (17% of Total)
Initiated for Non-BH Diagnoses:	565 (83% of Total)

Ex. 25

E. ANALYSIS OF CASES WHERE MEB WAS INITIATED AS BH DIAGNOSIS:

Of the MEBs Initiated due to BH Diagnosis:	117
Number of PTSD Cases:	39 (35%)
Number of Non-PTSD BH Cases:	78 (65%)

1) MEB INITIATED WITH PTSD DX:

Number of PTSD Cases:	39
Number Referred to FP:	23 (59%)
Number given BH Dx:	20 (87%)
Number given PTSD Dx:	13 (57%)
Number of PTSD Dx referred to FP resulting in non-PTSD Dx:	**10 (43%)**

2) MEB INITITAED WITH NON-PTSD BH DX:

Number of Non-PTSD Cases:	78
Number Referred to FP:	22 (28%)
Number given BH Dx:	22 (100%)
Number given PTSD Dx:	0 (0%)

3) ANALYSIS:

Of 23 cases referred to FP where PTSD listed reason for MEB:

- ***13 were diagnosed clinically with PTSD. (57%)***
- ***10 were diagnosed clinically without PTSD. (43%)***
- ***7 were diagnosed with a different BH condition. (30%)***
- ***3 resulted in no BH diagnosis. (13%)***

F. Total estimate of Soldiers whose cases need to be re-evaluated is 266

G. Recommend further record review of 85 of the 117 MEB cases initiated for BH reasons but terminated. These Soldiers were terminated due to conditions that need to be reviewed further, such as Chapter/UCMJ Action, AWOL, ETS, and downgraded profiles/Return to duty.

***Data collected by Western Regional Medical Command, 3-5 and 19-20 Feb 2012

DEPARTMENT OF THE ARMY
MADIGAN HEALTHCARE SYSTEM
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF

MCHJ-CSI

22 February 2012

MEMORANDUM FOR RECORD

SUBJECT: Character Reference for (b)(6) Commander, Madigan Healthcare System

1. This memo is to serve as a character reference for (b)(6) Commander of the Madigan Healthcare System. I am a Medical Service Corps officer and have been in the Army for 19 years. I have served as a Logistics Officer (70K), Operations Officer (70H), Medical Evacuation Officer (67J), and Health Systems Information Officer (70D) in many different capacities from platoon leader to company commander to chief information officer (CIO), and am currently the CIO for the Madigan Healthcare System. I have deployed multiple times to Korea, Central America, Egypt, Iraq, and Afghanistan.

2. I have known (b)(6) since 2009 when he was serving as the Multi-National Corps-Iraq (MNC-I) Surgeon while I was serving as the Chief Information Officer and MEDEVAC Operations Officer for Combined Joint Task Force (CJTF-101) in Afghanistan. We met in Qatar during a Central Command Medical Operations and Planning Conference. I immediately knew (b)(6) was a man of character and conviction. He provided an analysis of the current situation and plans for the eventual drawdown of combat forces in Iraq. He was honest, articulate and had a complete understanding of the combat situation there. He was not like an average Army doctor. His operational experience and natural leadership abilities made you want to listen and follow him.

3. In March 2011, (b)(6) took command of Madigan Healthcare System and I served as the Commander of Troops during the change of command ceremony. His leadership, attention to detail and commitment to the Soldiers in the formation was infectious as we went through rehearsals and the change of command. He ensured we all understood the standards and followed them. Instead of settling for 'good enough,' (b)(6) ensured we performed to our capability.

4. (b)(6) adopted a fiscally challenged hospital and one lacking disciplined processes. He immediately established priorities and direction for our organization. His leadership allowed us to establish strategic objectives and begin to transition to a responsible culture where everyone is held accountable for their actions. (b)(6) has been consistently firm and fair with everyone. Good leaders at Madigan Healthcare System welcomed his focus on standards and leadership. Weak leaders cowered under his command because they were finally being held accountable for their department or clinic's performance.

Ex. 26

MCHJ- CSI
SUBJECT: Character Reference for (b)(6) Commander, Madigan Healthcare System

5. (b)(6) vision of establishing a Soldier Centered Medical Home (SCMH) was nothing short of astounding. His drive and leadership in building the SCMH prototype caused a wave of support. His influence caused others to act instead of just sitting on the sidelines and observing. (b)(6) took significant risk in building a clinic offering specific medical services our soldiers deserve but rarely receive in the 'supply cages' of the Battalion Aid Stations they are forced to use. Knowing our Soldiers deserve better conditions, (b)(6) taught us the direct correlation the SCMH would have on readiness. His devotion and commitment to Soldiers is simply infectious and demonstrates his absolute loyalty to every Service Member we treat and support at Madigan.

6. (b)(6) is the type of man and leader our Army and country needs. He is the consummate professional. I would describe him as a leader first and an Army physician second. We need officers and leaders of his caliber in the Army Medical Department. I would be honored to serve with him in any capacity in the future, but especially in a combat environment because I trust him, believe in him and know his integrity is beyond reproach.

7. If you would like to discuss any of the matters surrounding this investigation with me, please contact me at (b)(6)

(b)(6)

RECEIVED BY INVESTIGATING OFFICER ON 9 MARCH VIA UNSOLICITED EMAIL.

(b)(6)

DEPARTMENT OF THE ARMY
MADIGAN HEALTHCARE SYSTEM
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF

MCHJ-CLLC

23 Feb 2012

MEMORANDUM FOR RECORD

SUBJECT: CHARACTER REFERENCE AND LETTER OF APPEAL FOR (b)(6) (b)(6)

1. This memo is to serve as a character reference and letter of appeal for (b)(6) (b)(6) Commander Madigan Healthcare System. I am writing to you to provide my perspective on the character of (b)(6)

2. I am the group practice manager for the Madigan-South Sound Community Based Medical Home. I am a retired Army Officer with almost 30 years of military service. I am a disabled veteran. I have been part of the Madigan staff as a civilian for almost 7 years after military retirement. I can tell you unequivocally that in my almost 37 years of service with the Army, I have never served a commander that was more concerned with the well being and health of soldiers and their families than (b)(6) (b)(6) and his wife are the most genuinely caring and honest people I have ever met. (b)(6) (b)(6) is the driving force behind the Soldier Centered Medical Home which has the potential to finally provide equity of care for our soldiers in garrison aid stations. (b)(6) (b)(6) plan will bring garrison health care throughout the Army on par with the care that is provided to family members and retirees in the hospital/clinic based system. (b)(6) cares intensely for and about service members. During the seven years I have been an employee of Madigan, (b)(6) in his short tenure has spent more time actually working and present at Madigan and on Joint Based Lewis McChord than previous commanders did during their entire tours of duty. (b)(6) has spent that time impressing his staff at all levels with the absolute responsibility to serve our beneficiaries honorably, honestly, and with upmost quality. (b)(6) has achieved wonders in a very short period of time through unrelenting personal effort. (b)(6) is the only one in my entire military experience which includes time working with many general officers that has actually proposed a plan to fix garrison medical care for soldiers. This may seem on the surface to be a small matter, but it took insight, courage, and plain hard work to get attention to bear on the age old problem of inequity of care for garrison soldiers in the battalion aid stations on military posts across the Army. He is a most honorable, selfless man who would never disadvantage a service member or do anything wrong.

(b)(6) works as hard as her husband. (b)(6) is honest, approachable, caring beyond limits, insightful, and willing to work in any capacity including cooking for an entire unit family readiness group meeting. (b)(6) is humble in all of her

Ex. 27

encounters. She is a blessing to the entire command and post. (b)(6) serves us all.

It would be a tragedy to lose (b)(6) The impact would be devastating to staff members and to our patients, but most of all to the service members they care for. Without the abilities of (b)(6) to guide the process, it is unlikely that the Soldier Centered Medical Home will become the robust reality it needs to be to serve our soldiers.

3. Thank you for considering my perspective. I would be honored to be contacted for any reason at my home (b)(6)
(b)(6)

(b)(6)

(b)(6)

RECEIVED ON 9 MAR 2012 BY UNSOLICITED EMAIL.

(b)(6)

From: (b)(6)
Sent: 08 March 2012 15:30
To: (b)(6)
Subject: (UNCLASSIFIED)
Attachments: (b)(6) character reference and appeal signed version.docx

Classification: UNCLASSIFIED
Caveats: NONE

Sir:
I am sending this email with the attached memo of character reference and appeal for intervention for (b)(6) I truly believe that what is happening is a travesty unbefitting a democracy or the military which (b)(6) selflessly serves. I am seriously concerned that this event will destroy or impair (b)(6) career with the result that the Soldier Centered Medical Home initiative will not reach its full potential to care for our soldiers. I am available at any time to answer questions or testify. Thank you for allowing me to contact you with my concerns.

(b)(6)

Classification: UNCLASSIFIED
Caveats: NONE

DEPARTMENT OF THE ARMY
CHILD, ADOLESCENT & FAMILY BEHAVIORAL HEALTH OFFICE
9913-A MADIGAN ANNEX
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF MCHO-CLC (BHO)

MEMORANDUM FOR RECORD

SUBJECT: CHARACTER REFERENCE AND LETTER OF SUPPORT FOR (b)(6)

1. The purpose of this letter is to provide information that may be used to support any of a number of investigations currently being conducted that involve the character and duty performance of (b)(6) Commander, Madigan Army Medical Center (MAMC).

2. I currently serve as the director of strategic communications for the Child, Adolescent, and Family Behavioral Health Office (CAF-BHO), a US Army Medical Command (MEDCOM) organization that falls within the Madigan "footprint". Although a MEDCOM organization, CAF-BHO is subject to guidance and direction established by the commander, MAMC and follows MAMC procedures, administrative and otherwise. Therefore, I have had virtually daily contact with (b)(6) since he took command.

3. Additionally I am a former major general in the United States Army and served as the commanding general, 25th Infantry Division (Light) (from 2002 until 2005) and as the commander Combined/Joint Task Force 76 in Afghanistan (from 2004-2005). (b)(6) (b)(6) was my staff surgeon in both capacities.

4. I can attest absolutely to the professionalism, leadership skills, and care and compassion that mark (b)(6) style and the execution of his duties while he worked for me and during the time that I have worked within his span of control. I hereby patently reject the charge that "he doesn't care about Soldiers or patients". The examples of his enormous efforts on behalf of those in his charge are too numerous to mention here. Any allegation of disregard for the welfare of Army Soldiers or family members will need to stand up in the face of overwhelming evidence to the contrary. It is impossible for me to believe that any meaningful body of valid or verifiable negative information to support such an allegation exists.

5. I am not an expert on the procedures that govern the determination of the behavioral health of a Soldier or the subsequent disposition of his or her case. But the establishment of some form of "forensic psychiatry team" (which took place in 2008, well before (b)(6) (b)(6) tenure) makes eminent sense to this impartial observer. A system that verifies the validity of a patient's claim and a related professional diagnosis—a form of oversight, or a "second look"—only ensures the integrity of the process and goes a long way to eliminating a negative factor that is affecting the morale of the entire force. The vast

Ex. 28

DEPARTMENT OF THE ARMY
CHILD, ADOLESCENT & FAMILY BEHAVIORAL HEALTH OFFICE
9913-A MADIGAN ANNEX
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF MCHO-CLC (BHO)

majority of the Army's population are professional and dedicated Soldiers who do their duty. The sense that it is very possible that malingerers or patients making false claims will "slip by" undetected—and perhaps rewarded—will have a corrosive effect on good order and discipline in the ranks.

6. As an aside and based on close to 40 years working in the DoD and other federal agencies, it is very difficult for me to believe that (b)(6) will get a "fair shake" from the ongoing investigations. The media frenzy that has surrounded this whole matter has inflamed numerous passions and reactions and will severely affect the objectivity of many of the witnesses who will be interviewed as part of the proceedings going forward. Additionally, Members of Congress and senior Army officials have let it be known how they feel the results of these investigations will or should come out, prejudicing their conduct and putting pressure on those conducting the investigations that will be nearly impossible to resist.

7. Point of contact for this memorandum is the undersigned.

ERIC T. OLSON
GS-15 and former Major General, US Army
Director, Strategic Communications
Child, Adolescent, and
Family Behavioral Health Office

RECIEVED ON 12 MARCH BY UNSOLICITED EMAIL.

(b)(6)

MCHJ-CLO 29 Feb 2012

MEMORANDUM FOR RECORD

SUBJECT: CHARACTER REFERENCE AND LETTER OF APPEAL FOR (b)(6)

(b)(6)

1. This memorandum is to serve as a character reference and letter of appeal for (b)(6) (b)(6) Commander, Madigan Healthcare System.

2. I have had the pleasure of working with (b)(6) and his wife (b)(6) since they arrived at Madigan and assumed command of the Madigan Healthcare System on March 10, 2011. His previous assignment was as the Chief of Clinical Operations, Western Regional Medical Command, Joint Base Lewis-McChord, Washington, and I had the pleasure of working with him for a brief period of time when he became one of the 15-6 Investigative Officers reviewing at that time what was the alleged mistreatment of the 41st Oregon National Guard and which later became known as fact.

3. (b)(6) came on board as my Commander after I had served a very long and trying time at Madigan as the Chief of Soldier Care Coordination Services. For a year plus, before he came on board, my staff and I were falsely accused of many wrong doings in an effort by several providers and staff from the medical and Behavioral Health clinics and the SRP site to move National Guard and Reserve Soldiers (specifically, the 41st OR NG) through the medical system at Madigan very quickly without taking care of their medical issues, and to make room for the Active Duty unit that was to be returning from Iraq shortly after. After listening to every single one of the Soldiers from the 41st NG unit who had a complaint (there were over 100 of them seen individually in my office), it became clear to me that this is not just a Madigan problem but a systemic problem that pervades the entire military community. I requested that each of these Soldiers make contact with their Senator and gave them Senator Ron Wyden's email address as the representative from the district that most of them lived in. I also became a Federal Whistleblower and reported the mistreatment of these Soldiers to (b)(6), who was at that time, the Director of Civilian Reprisal, and who was introduced to me by Senator Wyden.

E1.29

4. After working with (b)(6) on other large demobilizations, it became obvious that he is a Soldier's soldier, a leader who is extremely dedicated and focused on ensuring that all Soldiers, regardless of their military composition (Active component, Guard component, or Reserve component) are treated with respect and get the medical treatment they require and deserve. He made immediate positive changes to a very negative command climate.

5. (b)(6) was recruited as the Commander of Madigan specifically to clean up a gangrenous, festering mess left by the last command and what are longstanding problems at Madigan and within the military everywhere. The climate at Madigan has been focused on training young resident physicians on a wide breadth of illnesses and injury. But Soldiers and their medical issues have long been looked upon as annoyances and as problems. As one provider put it, "these Soldiers are abusers of the government dime." (b)(6) has done nothing less than to try and infiltrate this longstanding attitude among the providers and staff by standing in front every one of them in several Town Hall meetings, stating the facts and the truth, and by demanding that Soldiers and their families come first in every venue here at Madigan. I can tell you first hand that I have been extremely pleased with the progress that (b)(6) (b)(6) has made since coming into Command. I can also tell you that as the Federal Whistleblower, I have kept a finger on the pulse of this issue as well as maintaining contact with Senator Wyden's office and with the OR NG, and they too, have been pleased and satisfied with the progress made by (b)(6)

6. (b)(6) has taken the risks that pervade duty in theater and has stood shoulder-to-shoulder with our Soldiers. He could have left the Army long ago to make far more money as a Plastic Surgeon but took Army leadership positions instead. He is an excellent leader who doesn't just listen, but actually hears the words of those who work for him. I was having serious trust issues with the leadership here after holding this position for 3 years before (b)(6) first came on board. When in he took command, he came up to the Soldier Care Coordination Service, took me aside and said that he was going to do everything in his power to make things right and ensure that all Soldiers are taken care of appropriately. It took me awhile to trust him, but when he listened to what I had to say, and actually acted on my words, I started regaining that trust. The day that I told him that I could not and would not have my staff nurses work on the holiday after working 14-16 hour days during a 3 day weekend processing 3000+ Soldiers demobilizing from Iraq, he looked at me and said, (b)(6) I trust your judgment." From that point on we have had a mutual respect for each other. I have met many leaders as an enlisted Soldier, as the Executive Secretary for the Commanding General of the 3ID, and after 18 years of civilian service for the Federal Government, but I have never respected a leader more than I respect (b)(6) He and his wife (b)(6) perform selfless service every single day. (b)(6) reach out to everyone all the time and are completely all about and totally committed to taking care of the family members of deployed Soldiers as well as the Soldiers themselves.

7. Serving up (b)(6), (b)(6), and a few psychiatrists (who are following the American Psychologic Association and the American Academy of Psychiatry clinical practice guidelines and standards of care to the letter of the law) is the wrong answer. This approach abundantly displays cowardly senior leadership, more willing to appease Congressional leaders with a human sacrifice than actually rolling up their sleeves and working on a systems fix. This is not only just a Madigan problem. This is a systemic issue that affects tens of thousands of Soldiers, Sailors, Airmen, and Marines. A diagnosis is something that is made. It is not something to be given like some kind of gift that we present to someone because we like them or honor their service. Accurate diagnosis is a clinical imperative and absolutely crucial. It drives the treatment plan and the prognosis. It has nothing to do with money. Secretary of Defense Panetta is precisely correct. There needs to be an examination of how this issue affects all branches of the service, and a developing a joint solution is critical. Instead of paying Soldiers piece meal for each separate diagnosis, especially when some of these diagnoses are subjective and immeasurable, perhaps we should be giving them a set amount of money for serving in the war zone and have a cap. Regardless, it is essential and crucial that we come up with a joint solution.

8. Making (b)(6) a scapegoat for something that has been pervasive since approximately 2008 and is a cover up for leaders that are way above him in position and in rank is a travesty of justice. Any action taken against (b)(6) sends a message to the staff at Madigan and to Soldiers everywhere that dedication and honesty are not acceptable actions in the military. In the best interest of all armed forces this cannot be allowed to happen. And in support of the truth and the facts I will put my career on the line for (b)(6) and his wife (b)(6) My position at Madigan allows me to see at the street level what has rtaken place here in the past as well as in the present and I will use every means at my disposal to do what is right regardless of the personal cost or the short term public perception.

Sincerely,

(b)(6)

RECEIVED ON 12 MARCH BY UNSOLICITED EMAIL.

(b)(6)

Dear Congressman Dicks,

I write in reference to the ongoing investigation into the Madigan Army Medical Center's forensic psychiatry program, specifically the overturned PTSD diagnoses. I applaud anyone who looks after the welfare of Soldiers. If there is a truly a problem with this program, or any program within the Army's MEDCOM, I welcome the exposure and the chance to improve our medical system. However, I hope that you are encouraging Senator Murray to consider the welfare of all the Soldiers working and treated at Madigan, not just a relative few that contacted you, some of whom may have been coached and encouraged to file a complaint.

I work in a battalion subordinate to the hospital. I absolutely do not understand all the dimensions of the current situation. I can tell you the perception at my level and my concerns. (b)(6) is a fine Officer and Commander. His ethics and loyalty to the US Army are beyond question. He puts the welfare of all Soldiers first, both those assigned to and treated at Madigan. It appears that he is being set up to take a fall for the MEDCOM, similar to what happened to MG Weightman at the Walter Reed Army Medical Center in 2007.

I implore you; do not let politics sacrifice a great commander for a program that was instated long before his arrival. If there is a problem, let's identify and fix it. Look at the MEDCEN holistically. This is not a systemic issue; there are many great programs within the hospital that benefit the Army and the local community. Losing (b)(6) leadership would have second and third order effects that would negatively impact both the Madigan Army Medical Center and the MEDCOM. I am assuming that our congressional representatives are not using this matter as a political platform, but that they truly care for Soldiers. The best solution for all concerned is to reinstate our commander and assist him in making our MEDCEN a functional medical asset.

I sent similar correspondence to the office of Senator Patty Murray.

Sincerely,

(b)(6)

RECEIVED BY UNSOLICITED EMAIL ON 13 MARCH

(b)(6)

EX. 30